State of Florida

Department of Management Services

Division of State Group Insurance

THIRD PARTY ADMINISTRATIVE SERVICES

Contract Between

Blue Cross And Blue Shield Of Florida, Inc.

and

The Florida Department of Management Services

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CONTRACT

This Contract ("Contract") is entered between Blue Cross and Blue Shield of Florida, Inc. (d/b/a Florida Blue), a Florida corporation authorized to do business in Florida, with its principal corporate offices at 4800 Deerwood Campus Parkway, Jacksonville, Florida 32246, and the State of Florida, Florida Department of Management Services, with its principal offices at 4050 Esplanade Way, Tallahassee, Florida 32399-0950 (each, a "Party" and collectively, the "Parties").

RECITALS

WHEREAS, the Florida Department of Management Services issued Invitation to Negotiate (ITN) No. 12/13-047 soliciting firms interested in providing certain Third Party Administrative services; and

WHEREAS, Florida Blue responded to the solicitation; and following negotiations, the Department determined to accept Service Provider's offer and enter this Contract in accordance with the terms and conditions of the solicitation and the negotiation.

WHEREAS, Florida Blue has represented that it can and will perform the services described in this contract and has represented that it has the ability and corporate assets to fully perform this contract.

NOW THEREFORE, in consideration of the premises all of which are incorporated into this contract, the Parties agree as follows:

SECTION 1: DEFINITIONS

1.1 Definitions

Capitalized terms used in this Contract (including the Exhibits and any attachments thereto) without definition will have the meanings ascribed below:

"Acceptance" and "Accepted" means, with respect to each Deliverable, that the resulting services provided by the Service Provider have been formally acknowledged in writing by the Department as meeting the specified Deliverable requirements established in the Contract.

"Account Management Team" means those following individuals employed by the Service Provider:

Carlton Hobgood, VP Major Accounts

Jeannan Watson, VP Government Market Services

Mike Lewis, Director Public Sector

Richard Beeman, Account Manager

Mike Waters, Customer Service Manager

Ray Len, Analyst

Dr. Carmella Sebastian, Medical Director

"Benefits Document" means the document approved by the Florida Legislature in accordance with subsection 110.123(5), Florida Statutes, describing the scope of coverage, benefits available, limitations, restrictions and exclusions of the Plan, and the conditions under which Service Provider will pay claims. The Benefit Document is subject to modification by the Florida Legislature and the Department at any time. The covered and excluded services in the Benefits Document will be equivalent to those set forth in the schedule of minimum benefits together with any additional services expressly approved by the Department.

"Business Day" means any day of the week excluding weekends and holidays observed by state agencies pursuant to s. 110.117(1)(a)-(j), Florida Statutes.

"Calendar Day" means any day in a month, including weekends and holidays.

"Claim(s)" means an application for payment of or reimbursement for health care expenses incurred by Participants, which is filed in accordance with the Benefits Document and the Service Provider's and/or Department's requirements.

"CMS" means Centers for Medicare and Medicaid Services.

"Confidential Information" means information in the possession or under the control of the State or Service Provider that is exempt from public disclosure pursuant to Section I, Section 24 of the Constitution of the State of Florida; the Public Records Law, Chapter 119 of the Florida Statutes; or to any other provision that serves to exempt information from public disclosure.

"Contract" means this agreement between the Department and Service Provider consisting of, in order of precedence, the following documents:

1. This agreement, including Exhibit A (Administrative Requirements), Exhibit B (Performance Guarantees), Exhibit C (Plan Booklet and Benefit Document), Exhibit D (Approved Subcontractors), Exhibit E (Administrative Fees and Claims), and Exhibit F (Clinical Programs); and the Combined HIPAA Privacy Business Associate Agreement and Confidentiality Agreement and HIPAA Security Rule Addendum and HITECH Act Compliance Agreement.

2. The PUR Form 1000, General Contract Conditions, is incorporated herein by reference, The Parties agree that the following provisions of the PUR 1000 are not applicable to this Contract: 2-13, 17, 20-23, 26-29, 31, 34-35.

"Contract Administrator" means those persons designated pursuant to Section 11 of this Contract.

"Contract Manager" means those persons designated pursuant to Section 11 of this Contract.

"Covered Services" mean the services that are required to be provided as defined in the Benefits Document.

"Deliverables" mean those services, items and/or materials provided, prepared and delivered to the Department in the course of performance under this Contract by Service Provider.

"Department" means the Florida Department of Management Services or its designee. The Department reserves the right to contract with a third-party contractor to assume responsibility for the Department's administration of the Contract.

"Division" means the Department's Division of State Group Insurance.

"Effective Date" means January 1, 2015 at 12:00 AM.

"Eligible Dependents" means Dependents of Subscribers, as defined by the Florida Administrative Code and statutes.

"Estimating Conference Report" means the State Employees' Group Health Insurance Trust Fund Report on the Financial Outlook, typically published twice a year and developed pursuant to s. 216.134, Florida Statutes.

"ITN" means Invitation to Negotiate No. DMS 12/13-047 issued by the Department on June 24, 2013, and all addenda.

"Mathematically Accurate" means that the instruments, methods, data, numbers, assumptions and calculations are a correct representation of the outcomes.

"MMA" means the Medicare Modernization Act.

"Participants" means all Subscribers and their enrolled Eligible Dependents.

"People First" means the enterprise-wide suite of services used by the State to manage human capital including the administration of human resources, benefits, payroll and staffing. People First is the system of record for Plan eligibility.

"PEPM" means per Subscriber per month.

"PEPY" means per Subscriber per year.

"Performance Standards" means specific measurement indicators assigned to Contract tasks representing timeliness and quality of task output.

"Plan" means the State Group Insurance Program's preferred provider organization benefits plan, which is included in the State's group insurance program established by section 110.123(3)(b), Florida Statutes, and implemented by Florida Administrative Code. The Plan is a preferred provider network plan as defined in section 627.6471, Florida Statutes.

"Plan Year" is based on the calendar year from January 1 to December 31.

"PMPM" means per Participant per month.

"PMPY" means per Participant per year.

"Program" means the State Group Insurance Program defined in 110.123(3), Florida Statutes.

"Run-Out Claims" will mean a Claim for medical expenses incurred by a Plan Participant during the term of the Contract which is received by the Service Provider after termination of the Contract and within sixteen (16) months from the date that the health care services relating to such Claim were rendered.

"ROI" means Return of Investment, which is the guarantee of the annual gross savings realized from a program relative to the cost of the program.

"Secretary" means the Secretary of the Department or his/her designee.

"Services" means Third Party Administration services to be performed by Service Provider as specified in this Contract, including the requirements of the Exhibits to this Contract. The term "Services" includes, but is not limited to, all Deliverables and any unspecified service that is inherent in proper delivery of a specified service or Deliverable. During the term of the Contract, the Department will have the right to add or delete services and products. If the Department elects to add services or products, the Service Provider and the Department will negotiate a mutually agreed amendment to the Contract.

"Service Provider," "Respondent" or "Vendor" means Florida Blue, the Third Party Administrator.

"State Group Insurance Program" means the employee benefit program established by s. 110.123, Florida Statutes.

"Subcontractor" refers only to Service Provider's subcontractors that deliver third party administrative services to be performed by the Service Provider as specified in this Contract, including the requirements of the Exhibits to this Contract. The term does not include medical providers and pharmacy providers who provide care to a Participant.

"Subscriber" or "Enrollee" means the enrolled employee, retiree or COBRA participant that is the primary insured, as defined in Florida Administrative Code.

"Written Clarifications and Modifications" mean all written correspondence as attached and incorporated herein by reference into the Contract.

1.2 Rules of Interpretation

Unless otherwise indicated or otherwise required by the context, the following rules of interpretation apply:

(a) Reference to, and the definition of, any document (including any exhibits) will be deemed a reference to such document as it may be amended, supplemented, revised or modified upon mutual agreement by the Parties in the method prescribed herein;

(b) All references to a “Section,” "Exhibit," “Appendix” or “Attachment” are to a Section, Exhibit or Attachment of this Contract;

(c) The table of contents and Section headings and other captions are for reference purposes only and do not limit or affect the content, meaning or interpretation of the text;

(d) All singular terms will include the plural and vice versa. The masculine, feminine or neutral gender will include all genders;

(e) The words “include”, “includes” and "including" are deemed to be followed by the phrase “without limitation”;

(f) Any reference to a governmental entity or person will include the governmental entity’s or person's authorized successors and assigns; and

(g) The words “quarterly,” “on a quarterly basis,” “quarterly meeting” or other similar terms mean, unless otherwise stated herein, once every three (3) months, beginning January 1, 2015, unless otherwise stated.

1.3 Hierarchy of Documents

Contract Interpretation: In the event of conflict among contract documents, the order of precedence for the Contract will be as listed in the definition of the term “Contract.” If the Contract terms are inconsistent with the benefit and coverage provisions of the Benefits Document or statute, then the provisions of the Benefits Document or statute will prevail.

SECTION 2: TERM, SCOPE AND COMPENSATION

2.1. Term

2.1.1 Initial Term. The initial Contract term is four (4) years and will commence on the Effective Date and end after 11:59:59 P.M., on December 31, 2018, unless extended, terminated or renewed as provided herein. The Parties acknowledge that the Plan will not be implemented and administered under this Contract until January 1, 2015. While pre-implementation services will be required, payment will be made only in accordance with the fees listed in the financial terms section of this Contract as due.

2.1.2 Department’s Right to Renew. Upon notice to Service Provider at least six (6) months prior to expiration, the Department may renew the Contract for up to four (4) additional years at the same, or lower than, the prices specified in this Contract at its sole option and discretion. Such renewal will be binding on the Service Provider and may be in one or multiple year increments at the Department’s sole option. If Service Provider agrees to pricing concessions or is obligated to provide alternate pricing terms pursuant to Section 11.8, the renewal will specify

the adjusted price.

The Department will not be charged any costs for the renewal. The renewal is contingent upon the availability of funds.

2.1.3 Department's Right to Terminate for Convenience. Notwithstanding to the contrary, the Department, by sixty (60) days advance written notice to Service Provider, may terminate the Contract in whole or in part when the Department determines in its sole discretion that it is in the Department's best interest to do so. Service Provider will not furnish any Services after the effective date of termination, except as necessary to complete the continued portion of the Contract, if any. Service Provider will not be entitled to recover any consequential damages including but not limited to cancellation charges and lost profits. If this Contract is terminated for convenience prior to January 1, 2015, the Department will reimburse Service Provider for costs actually incurred for authorized Services satisfactorily performed prior to the notice of termination.

2.2 Scope of Work

Service Provider will provide all labor, materials and supplies necessary to provide the Services as described in this Contract. The Service Provider agrees to periodic reviews by the Department of Service Provider's performance to improve delivery of the scope of work. Corrective work to comply with the requirements of this Contract will be performed by the Service Provide at its expense, and the Service Provider will not be entitled to any compensation for such corrective work.

The Department may unilaterally require, by written order, changes altering, adding to or deducting from the Services, provided that such changes are within the general scope of the Contract. The Department may make an equitable adjustment in the Contract price or performance schedule if the change affects the cost or time of performance. Such equitable adjustments require the written consent of Service Provider, which will not be unreasonably withheld. If the parties fail to agree to an equitable adjustment the dispute must be resolved pursuant to Section 9.

2.3. Department's Right to Suspend Work

The Department may in its sole discretion suspend any or all Services under the Contract, at any time, when in the best interests of the Department to do so. The Department will provide Service Provider written notice outlining the particulars of suspension. Examples of the reason for suspension include, but are not limited to, budgetary constraints, declaration of emergency or other like circumstances. After receiving a suspension notice, Service Provider will comply with the notice. During the suspension of work, an appropriate equitable adjustment in the Contract price will be made, as described in Section 2.2.

2.4. Department's Obligation to Supply Data to Service Provider

The Department and/or its designee will supply all enrollment and personnel data and information necessary for Service Provider to provide the Services.

2.5. Compensation

The Service Provider agrees to perform all Services for the compensation and financial arrangements set forth in this Contract. No additional compensation will be allowed unless specifically set forth in Exhibit E.

This Contract is subject to the transaction fee contained in s. 287.057(22)(c), Florida Statutes and the Service Provider will comply with the timely reporting and payment of such fee.

2.5.1 Specific Appropriation. The funds from which the state will make payment for administrative services under the Contract are identified in Specific Appropriation 2777 of the 2013 General Appropriations Act.

SECTION 3: CONTRACT ADMINISTRATION

3.1. Contract Management

3.1.1 Ownership of Deliverables and Retention of Records. All Deliverables, and any papers, documents, materials and other items prepared by Service Provider for purposes of the Contract will be the property of the Department and will be available to the Department at any time. The Department will have the right to use the same without restriction and without any additional compensation to Service Provider.

Service Provider will retain (i) sufficient documentation to substantiate claims for payment under the Contract, and (ii) all other records, electronic files, papers and documents which were made for purposes of the Contract. Such records will include all records in all types of media and all formats maintained by Service Provider directly relating to the Services. Service Provider will retain all such records, papers and documentation in compliance with Record Retention Schedules published by the State of Florida Department of State. Prior to the destruction of any such records, papers or documentation, Service Provider will consult with and obtain the prior written approval of the Department.

3.1.2 Major Organizational Changes. The Service Provider recognizes and agrees that award of the Contract was predicated upon features of Service Provider's business organization as set forth by the Service Provider's during negotiations. If the Service Provider transfers or sells more than 49.9% of its equity shareholder interests or allows a sale of substantially all of its assets, as determined by the Department, the Department may terminate this Contract upon no less than 30 days written notice. Such termination will not entitle the Service Provider to damages of any kind, provided that Service Provider will be entitled to compensation for work performed prior to the effective date of the termination.

3.1.3 Review of Standard Operating Procedures. On an annual basis, Service Provider will audit, review and assess its performance on Claims handling (processing, suspending and adjusting claims) as well as customer service inquiries made by phone, mail, e-mail and other delivery modes. At the time of the audit, Service Provider will advise the Department on how the following areas are monitored to ensure quality, including but not limited to: technical, Claims sample, Claims and inquiry turnaround times, financials, telephone and customer service, and

Claim payments.

3.2. Warranty

Generally: Service Provider will deliver the Services in a professional, workmanlike manner in accordance with the standards and quality prevailing among first-rate nationally recognized firms in the industry and in accordance with this Contract.

Remedies: In the event that the Department discovers that any Services are not delivered in accordance with this Contract, Service Provider will promptly correct, cure, replace or otherwise remedy such performance at no cost to the Department. However, this provision does not affect any other remedy or the Department's right to terminate services for breach or default of the Contract.

This Section will survive termination of this Contract.

3.3. Employees and Subcontractors

3.3.1 Hiring of Other Party's Personnel. Except as expressly authorized in writing in advance, no Party will employ or contract with, whether as a partner, employee or independent contractor, directly or indirectly, any of the other Parties' personnel during their participation in the contracted services. "Personnel" will include any individual or company a Party employs as a partner, employee or independent contractor and with which a Party comes into direct contact in the course of the provision of the Services.

3.3.2 No Joint Employees. Neither Party will be deemed a joint employer of the other's employees and each Party being responsible for any and all of its employees. Neither Party's employees will be deemed leased employees of the other Party for any purpose.

3.3.3 Subcontractors. Service Provider is responsible for the acts or omissions of all Subcontractors, if any, it uses in the provision of the Services during the term of the Contract. The Department will have no liability of any kind for Subcontractor demands, loss, damage, negligence or any expense relating, directly or indirectly, to Subcontractors.

Service Provider will not subcontract any of the Services or enter into any subcontracts or change approved Subcontractors (including their key personnel and/or location of processes for the Services) without the express written consent of the Department. In seeking such consent, Service Provider will give the Department prior notice of at least sixty (60) calendar days or, in case of an emergency, as soon as practical. Each approved subcontract will be subject to the same terms and conditions as the Contract. For purposes of this subsection, medical and pharmacy providers are not considered to be Subcontractors.

3.3.4 Employment of State Workers. During the term of the Contract, Service Provider will not knowingly employ, subcontract with or sub-grant to any person (including any non-governmental entity in which such person has any employment or other material interest as defined by Section 112.312(15), Florida Statutes), who is employed by the Department or who has participated in the performance or procurement of the Contract, except as provided in Section 112.3185, Florida Statutes.

Service Provider will take all actions necessary to ensure that Service Provider's employees, Subcontractors, Providers and other agents are not employees of the Department.

3.3.5 Employee and Subcontractor Security Requirements. All Service Provider employees, Subcontractors and agents performing work under the Contract must comply with all security and administrative requirements of the Department.

A. Background Screening

In addition to any background screening required by the Service Provider as a condition of employment, the Service Provider warrants that it will conduct a criminal background screening of, or ensure that such a screening is conducted for, each of its employees, subcontractor personnel, independent contractors, leased employees, volunteers, licensees or other person, hereinafter referred to as "Person" or "Persons," operating under their direction with access to State of Florida Data.

"Access" means to approach, instruct, communicate with, store data in, retrieve data from, or otherwise make use of any resources of a computer, computer system or computer network.

"Data" means a representation of information, knowledge, facts, concepts, computer software, computer programs or instructions, whether said information is confidential information or personal health information. Data may be in any form, including but not limited to, in storage media, stored in the memory of the computer, in transit or presented on a display device, or a hard copy.

The Service Provider will ensure that the background screening is conducted on all Persons directly performing services under the Contract whether or not the Person has access to State of Florida Data, as well as those persons who are not performing services under the Contract but have access, including indirect access, to State of Florida Data.

The minimum background check process will include a check of the following databases through a law enforcement agency or a Professional Background Screener accredited by the National Association of Professional Background Screeners or a comparable standard:

- Social Security Number Trace; and
- Criminal Records (Federal, State and County criminal felony and misdemeanor, national criminal database for all states which make such data available).

The Service Provider agrees that each Person will be screened as a prior condition for performing services or having access to State of Florida Data. The Service Provider is responsible for any and all costs and expenses in obtaining and maintaining the criminal background screening information for each Person described above. The Service Provider will maintain documentation of the screening in the Person's employment file. The Service Provider will abide by all applicable laws, rules and regulations including, but not limited to the Fair Credit Reporting Act and/or any equal opportunity laws, rules, regulations or ordinances.

1. Disqualifying Offenses

If at any time it is determined that a Person has a criminal misdemeanor or felony record regardless of adjudication (e.g., adjudication withheld, a plea of guilty or nolo contendere, or a guilty verdict) within the last ten (10) years from the date of the court's determination for the crimes listed below, or their equivalent in any jurisdiction, the Service Provider is required to immediately remove that Person from any position with access to State of Florida Data or directly performing services under the Contract. The disqualifying offenses are:

- Computer related or information technology crimes
- Fraudulent practices, false pretenses and frauds, and credit card crimes
- Forgery and counterfeiting
- Violations involving checks and drafts
- Misuse of medical or personnel records
- Felony theft

If the Service Provider finds a Disqualifying Offense for a Person within the last ten (10) years from the date of the court's disposition, it may obtain information regarding the incident and determine whether that Person should continue providing services under the Contract or have access to State of Florida Data. The Service Provider will consider the following factors only in making the determination: i.) nature and gravity of the offense, ii.) the amount of time that lapsed since the offense, iii.) the rehabilitation efforts of the person and iv.) relevancy of the offense to the job duties of the Person. If the Service Provider determines that the Person should be allowed access to State of Florida Data, then Service Provider will present its findings and explain its determination in writing to the Department. The Department will have final decision-making authority as to whether the Person will be allowed access to State of Florida Data. During the process of collecting the information and making a decision, the Service Provider will not allow the Person to perform services or have access to State of Florida Data.

2. Self-Disclosure

The Service Provider will ensure that all Persons have a responsibility to self-report within three (3) calendar days to the Service Provider any updated court disposition of any criminal misdemeanor or felony record regardless of adjudication (adjudication withheld, a plea of guilty or nolo contendere or a guilty verdict). The Service Provider will immediately assess whether to disallow that Person access to any State of Florida Data or from directly performing services under the contract. Additionally, the Service Provider will require that the Person complete an annual certification that they have not received any additional criminal misdemeanor or felony record regardless of adjudication (adjudication withheld, a plea of guilty or nolo contendere or a guilty verdict) for the Disqualifying Offenses and will maintain that certification in the employment file.

In addition, the Service Provider will ensure that all Persons have a responsibility to self-report to the Service Provider, within three (3) calendar days, any arrest for any Disqualifying Offense. The Service Provider will notify the Contract Manager within 24 hours of all details concerning any reported arrest.

3. Refresh Screening

The Service Provider will ensure that all background screening will be refreshed every five (5) years from the time initially performed for each Person during the Term of the Contract.

4. Monthly Reporting

The Service Provider is required to submit a written report to the Department within fifteen (15) days from the end of each month listing those Persons who have been screened and those Persons with Disqualifying Offenses who have been removed from performing services or having access to State of Florida Data. The monthly reporting by the Service Provider will at a minimum include the name of the Person, the title of the Person's position, a description of the job, and the name of and date of the Disqualifying Offense.

The Service Provider will also include in the monthly report a list of those Persons who have reported being arrested, as well as providing an update on the status of the court's proceedings and ultimate disposition (see A 2. above) for all Persons included on the monthly report.

B. Duty to Provide Secure Data

The Service Provider will maintain the security of State of Florida Data including, but not limited to, a secure area around any display of such Data or Data that is otherwise visible. The Service Provider will also comply with all HIPAA requirements and any other state and federal rules and regulations regarding security of information.

C. Department's Ability to Audit Screening Compliance and Inspect Locations

The Department reserves the right to audit the Service Provider's background screening process upon two days prior written notice to the Service Provider during the Term of the Contract. Department will have the right to inspect the Service Provider's working area and/or location upon two business days prior written notice to the Service Provider to ensure that access to the State of Florida Data is secure and in compliance with the Contract and all applicable state and federal rules and regulations.

D. Indemnification

The Service Provider agrees to defend, indemnify and hold harmless the Department, the State of Florida, its officers, directors and employees for any claims, suits or proceedings related to a breach of this warranty. The Service Provider will include credit monitoring services at its own cost for those individuals affected or potentially affected by a breach of this warranty for a two (2) year period of time following the breach.

3.3.6 Work Locations; No Off-shoring of Data. Unless otherwise agreed in writing, (i) Service Provider and its subcontractors and agents will not perform any of the Services from outside of the United States, and (ii) Service Provider will not allow any State of Florida Data to be sent by any medium, transmitted or accessed outside of the United States.

Service Provider agrees that a violation of item (ii) above will result in immediate and irreparable harm to the Department and will entitle the Department to a credit of $50,000 per violation, with a total cap of $500,000 per event. This credit is intended only to cover the

Department's internal staffing and administrative costs as well as the diminished value of Services provided under the Contract, and will not preclude the Department from recovering other damages it may suffer as a result of such violation. For purposes of determining the damages due hereunder, a group of violations relating to a common set of operative facts (e.g., same location, same time period, same off-shore entity) will be treated as a single event. A violation of this provision will also entitle the Department to recover damages, if any, arising from a breach of this section and constitutes an event of default.

3.3.7 E-Verify. Pursuant to State of Florida Executive Order No.: 11-116, Service Provider is required to utilize the U.S. Department of Homeland Security's E-Verify system to verify the employment of all new employees hired by Service Provider during the Contract term. Also, Service Provider will include in related subcontracts a requirement that Subcontractors performing work or providing services pursuant to the state contract utilize the E-Verify system to verify employment of all new employees hired by the Subcontractor during the Contract term.

3.3.8 Scrutinized Company List. In executing this Contract, Contractor certifies that it is not listed on either the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, created pursuant to section 215.473, Florida Statutes. Pursuant to section 287.135(5), Florida Statutes, Contractor agrees the Department may immediately terminate this contract for cause if the Contractor is found to have submitted a false certification or if Contractor is placed on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List during the term of the Contract.

3.4. Acceptance of Deliverables

The Department will conduct its acceptance review in a manner so as to identify how the Deliverable materially fails to conform to the Contract (each such respect, "Nonconformity"). After the Department notifies Service Provider in writing of any Nonconformity, specifying for each Nonconformity, how the Deliverable materially fails to meet the Contract. Service Provider will correct such Nonconformity within five (5) business days, or proceed on another mutually acceptable basis as set forth in writing. The Department will then verify that the previously reported Nonconformity has been corrected and report any Nonconformity caused by the correction of the previous Nonconformity.

SECTION 4: AUDITS

The Department has the right to conduct performance and/or compliance audits related to this Contract of any and all areas of Service Provider, and/or Subcontractors approved in conformity with Section 3.3.3 of this Contract. The Department may at any time enter and inspect the Service Provider's physical facilities where operations required under this Contract are performed, upon reasonable notice. Except in emergency situations, reasonable notice will be provided for audits conducted at Service Provider's premises. Audits may include but will not be limited to audits of procedures, computer systems, claims files, provider contracts, service records, accounting records, internal audits, quality control assessments and any and all

applicable health care provider contracts and service programs related to this Contract. Service Provider will cooperate and work with any representative selected by the Department to conduct said audits and inspections, including but not limited to other state agencies. The Service Provider will make available all data or information requested by the Department in furtherance of an audit. The audits will comply with the Confidentiality Protocol set forth within this Contract.

Service Provider recognizes and acknowledges that release statements from its health care providers are not required for the Department or its designee to conduct compliance and performance audits on any of the Service Provider's contracts relating to this Contract.

The right of the Department to perform audits and inspections will survive the expiration or termination of this Contract. The Department will use reasonable efforts to minimize the number and duration of such audits or inspections conducted and to conduct such audits and inspections in a manner that will minimize the disruption to Service Provider's business operations.

This provision will not limit the rights of other state agencies or officers, such as the State's Chief Financial Officer and the Office of the Auditor General, to perform audits and inspections independently of, or in conjunction with, the Department.

Except for the annual SSAE 16 audit, the Department will be responsible for the independent third party auditor costs associated with any audit performed.

SECTION 5: DIVERSITY

It is the policy of the State that Minority Business Enterprises, Woman-Owned Business Enterprises and Service-Disabled Veteran Business Enterprises (as those terms are defined by Florida Statutes), have the maximum practicable opportunity to participate in performing contracts let by any state agency. Service Provider will carry out this policy in the awarding of subcontracts to the fullest extent consistent with efficient Contract performance by reasonably considering such Business Enterprises as Subcontractors for the Services. Service Provider further agrees to comply with all controlling laws and regulations respecting the participation of such Business Enterprises in the provision of the Services and to reasonably cooperate in any studies or surveys as may be conducted by the State of Florida to determine the extent of Service Provider's compliance with this Section.

SECTION 6: LIQUIDATED DAMAGES

6.1. Generally

Time is of the essence in performing the Contract; this is true generally and particularly with respect to achieving an Effective Date of January 1, 2015 and meeting performance guarantees. Service Provider acknowledges that untimely performance or other material noncompliance will damage the Department, but by their nature such damages are impossible to ascertain presently and will be difficult to ascertain in the future. The issues involved in determining the amount of damages will be multiple and complex, and will be dependent on many and variant

factors, proof of which would be burdensome and require lengthy and expensive litigation, which the Parties desire to avoid. Accordingly, the Parties agree that it is in the Parties' best interests to agree upon a reasonable amount of liquidated damages, which are not intended to be a penalty and are solely intended to compensate for unknown and unascertainable damages. The Parties acknowledge that liquidated damages are contemplated by section 110.123(3)(d)3, Florida Statutes.

6.2. Implementation Delays

(a) Untimely Plan Implementation: If Service Provider fails to achieve Plan implementation by January 1, 2015, it will pay liquidated damages of $3 million per month, unless any such delay is due to the Department's failure to comply with the defined timeline. Service Provider will pay this amount of liquidated damages for every full or partial calendar month thereafter until the Plan is fully implemented. For example, if the Plan is implemented any day between January 2 and February 1, total damages will be $1,000 per service provider plan participant per month, not to exceed $3 million; if the Plan is implemented any day between February 2 and March 1, total damages will be $1,000 per service provider plan participant per month, not to exceed $6 million.

In addition to the above, Service Provider will pay the indicated amount of liquidated damages for each calendar day beyond the date indicated in the Service Providers Implementation Plan, for any Implementation Plan milestone that is not timely implemented, including but not limited to the following:

Milestone	Completion Date	Liquidated Damages
Eligibility		
Automation finalized	October, 30, 2014	$10,000/day
Load production eligibility file	December 12, 2014	$100,000/day
Mail identification cards	December 12, 2014	$100,000/day
Finance		
Finalize billing arrangements	October 10, 2014	$10,000/day

(b) Failure to Achieve Progress Towards Other Implementation Milestones: If Service Provider fails to achieve the scheduled progress toward any other Implementation Plan milestone, the Department at its sole discretion may assess an underperformance fee of $10,000 per calendar day until the day Service Provider attains substantial progress in adherence with the Implementation Plan schedule.

6.3. Failure to Meet Other Performance Guarantees

(a) Service Provider agrees to payment of additional liquidated damages ("Performance Guarantees") if it fails to meet the performance standards set forth within Exhibit B to this Contract.

(b) Performance Guarantees are intended only to cover the Department's internal staffing and administrative costs and the diminished value of the Services provided under the

Contract. In accepting liquidated damages, the Department does not waive its right to pursue other remedies provided for under this Contract, including a claim for any damages not covered by the liquidated damages.

(c) Notwithstanding anything in the Contract to the contrary, the total of any and all Performance Guarantees paid or to be paid by Service Provider pursuant to this Contract for any calendar quarter will not exceed 100% of the Compensation due under Section 2.5 above.

(d) Upon mutual agreement of the Parties, Performance Guarantees may be suspended from time to time for special circumstances. Suspension of a Performance Guarantee will not excuse Service Provider from accumulating data relevant to that Performance Guarantee and reporting such data to the Department as part of the management reports delivered pursuant to this Contract.

(e) Service Provider will provide the Department with a Performance Standards Guarantee Report for all Performance Guarantees prescribed by Exhibit B on a quarterly basis. For each Performance Guarantee that the Service Provider fails to meet, based on the Performance Standards Guarantee Report, the Service Provider will provide appropriate payment to the Department within 45 calendar days of end of the reporting quarter.

(f) The Department may require the Service Provider to propose and implement a reasonable Corrective Action Plan to address and correct the root causes of any missed Performance Standard.

(g) The inclusion of Performance Guarantees in this Agreement is intended to address unsatisfactory performance in the context of ongoing operations without resort to the default provisions set forth in Section 8 of the Contract. However, if Service Provider's performance falls below the minimum level of performance for the same Performance Guarantee for three (3) quarters and such failure is not otherwise excused, then the Department may declare an Event of Default.

(h) Service Provider will be excused for failing to meet any Performance Standard to the extent such failure is caused by the Department not performing any of its obligations under the Contract.

(i) Service Provider will advise the Department in writing as soon as possible of any circumstance or occurrence which would excuse or affect Service Provider's ability to achieve any of the Performance Standards. In all such cases, Service Provider will continue to make all reasonable efforts to achieve the Performance Standards.

SECTION 7: INSURANCE

7.1. Insurance Coverage

During the Contract term, Service Provider will, at its sole expense, continuously maintain commercial insurance of such a type and with such terms and limits as may be reasonably associated with the Contract and as required by law. Providing and maintaining adequate insurance coverage is a material obligation of Service Provider and performance may not

commence on this Contract until such time as insurance is secured by the Service Provider and is approved by the Department, which approval will not be unreasonably be withheld or delayed. The limits of coverage under each policy do not limit Service Provider's or Subcontractor's liability and obligations under the Contract. Unless otherwise agreed in writing by the Department, all insurance policies must be through insurers authorized or eligible to write policies in Florida.

(a) Commercial General Liability. The Service Provider must continuously maintain commercial general liability insurance (inclusive of any amounts provided by an umbrella or excess policy) in the face amount of Nineteen Million Dollars ($19,000,000.00).

(b) Business Interruption Insurance. Service Provider must continuously maintain business interruption insurance coverage in the face amount of Nineteen Million Dollars ($19,000,000.00).

(c) Workers' Compensation Insurance. The Service Provider must continuously maintain workers' compensation insurance coverage as required under all relevant workers' compensation statutes under applicable state and federal laws. The insurance must cover all of Service Provider's employees connected with the provision of Services under this Contract. Service Provider will require any Subcontractor similarly to provide workers' compensation insurance coverage for all of the Subcontractor's employees unless such employees are covered by the Service Provider.

(d) Professional Indemnity Insurance. The Service Provider must continuously maintain professional indemnity insurance that must cover Professional Liability and Error and Omissions in the face amount of Nineteen Million Dollars ($19,000,000.00). Service Provider will indemnify, defend and hold harmless the Department and its employees and agents, from and against any third party claims, demands, loss, damage or expense caused by Service Provider in connection with the performance of the Services relation to Professional Liability and Error and Omissions. Each insurance certificate for such policy must include an agreement that the insurer will provide thirty (30) calendar days prior written notice to the Department of cancellation for any coverage.

The Service Provider will provide all certifications of insurance as proof of insurance including renewed or replacement evidence of coverage at least thirty (30) days prior to the expiration or termination of any insurance policy.

7.2. Performance Bond

In accordance with Section 110.123(3)(d)2, Florida Statutes, within 30 days executing the Contract, Service Provider will furnish at no additional cost to the Department, a performance bond or, if approved by the Department, a negotiable irrevocable letter of credit or other form of security (collectively the bond) for the performance of work under the Contract in an amount equal to or greater than the Service Provider's annual ASO fee(s). However, at no time will the bond amount be less than $10,000,000. The bond will be maintained throughout the term of the Contract, issued by a reliable surety company which is licensed to do business in the State of Florida, as determined by the Department, and must include the following conditions:

1) Obligee/Beneficiary: The Department will be named as the obligee/beneficiary of the bond. Service Provider's bond will provide that the insurer or bonding company will provide performance and/or payment remuneration directly to the Department.

2) Notice of Attempted Change: The Department will receive thirty (30) days prior written notice of any attempt to cancel or to make any other material change in the status, coverage or scope of the required bond or of Service Provider's failure to pay bond premiums.

3) Premiums: The Department will not be responsible for any premiums or assessments on the bond.

4) Purpose of Bond: The bond is to protect the Department against any loss sustained through failure of Service Provider or any of its employees, officers, directors, agents and representatives to accurately perform the Services required by the Contract for the entire term of the Contract. No compensation will be due to Service Provider until the performance bond is in place and approved by the Department in writing.

SECTION 8: DEFAULT AND REMEDIES

8.1. Service Provider Events of Default

Any one or more of the following events will constitute an "Event of Default" on the part of Service Provider hereunder:

a) Service Provider fails to pay any sum of money due hereunder; or

b) Service Provider fails to provide the Services as required under the Contract; or

c) Service Provider employs an unauthorized alien in the performance of any work required under the Contract; or

d) Service Provider fails to correct work that the Department has rejected as unacceptable or unsuitable; or

e) Service Provider discontinues the performance of the work required under the Contract; or

f) As specified by the Department, Service Provider fails to resume work that has been discontinued; or

g) Service Provider abandons the project; or

h) Service Provider becomes insolvent or is declared bankrupt; or

i) Service Provider files for reorganization under the bankruptcy code; or

j) Service Provider commits any act of bankruptcy or insolvency, either voluntarily or involuntarily; or

k) Service Provider fails to promptly pay any and all taxes or assessments imposed by and legally due the Department or federal government; or

l) Service Provider makes an assignment for the benefit of creditors without the approval of the Department; or

m) Service Provider made or has made a material misrepresentation or omission in any materials provided to the Department; or

n) Service Provider commits any material breach of the Contract; or

o) Service Provider fails to maintain the performance bond; or

p) Service Provider fails to maintain the required insurance herein; or

q) The Department determines that the Surety executing a bond, if applicable, used to secure Service Provider's performance of its obligations hereunder becomes unsatisfactory; or

r) Service Provider transfers ownership in violation of the Contract; or

s) Service Provider utilizes a vendor in the performance of the work required by the Contract which has been placed on the Department's Convicted Vendors List; or

t) Service Provider is suspended or is removed as an authorized vendor by any state or federal agency or Service Provider is convicted of a felony; or

u) Service Provider refuses to allow public access to all documents, papers, letters or other material subject to the provisions of Chapter 119, Florida Statutes, made or received by Service Provider in conjunction with the Contract and not otherwise deemed confidential, proprietary or a trade secret; or

v) Service Provider refuses to allow auditor access as required by the Contract; or

w) Violation of Section 3.3.6 (Work Locations; No Off-shoring of Data), or Service Provider's permitting State Data to be transmitted, viewed or accessed outside of the United States; or

x) Service Provider's change of Subcontractors in violation of Section 3.3.3 of the Contract; or

y) For any other cause whatsoever that Service Provider fails to perform in an acceptable manner as determined by the Department, including but not limited to failure to meet performance standards and/or pay associated guarantees; or

z) Failure to timely notify the Department upon discovery of problems or issues impacting claims processing related to the Plan; or

aa) Failure to provide complete paid claims data to the Department's Health Insurance Management Information System vendor; or

bb) Failure to timely report and pay the transaction fee contained in s. 287.057(22)(c), Florida Statutes, as detailed in Section 2.5 (Compensation); or

cc) Failure to meet the same monthly Performance Guarantee for at least three (3) months.

8.2. Department Remedies in the Event of Default

Subject to the notice and cure provisions Florida Administrative Code, and subject to the dispute resolution process in this Contract, upon the occurrence of an "Event of Default" on the part of Service Provider, the Department is entitled to one or all of the following remedies:

(a) Equitable Relief.

(b) Monetary Damages (including any re-procurement costs).

(c) Termination of Contract.

8.3. Department Events of Default

Any material breach by the Department of the Contract will (after the required notice, dispute resolution process and cure period) constitute an "Event of Default" on the part of the Department. The cure period for a material breach by the State or the Department will be forty-five (45) calendar days from receipt of notice of material breach.

8.4. Service Provider Remedies in the Event of Default

Upon occurrence of an "Event of Default" on the part of the Department, Service Provider is entitled to any one or all of the following remedies.

(a) Equitable Relief.

(b) Monetary Damages. Service Provider is entitled to recover any Compensation

due under Section 2.5 for Services actually provided in accordance with the Contract but not paid by the Department. Service Provider is not entitled to, and will not seek, any other reimbursement or payment, or damages, including but not limited to lost profits. Prior to the Department's payment to Service Provider as the result of termination, Service Provider will have satisfied all undisputed obligations to third parties relating to the Contract.

8.5. Rights Cumulative, No Waiver

The rights and remedies provided and available to the Department and Service Provider in this Section 8 are distinct, separate and cumulative remedies, and no one of them, whether or not exercised by a party, will be deemed to be in exclusion of any other. The election of one remedy will not be construed as a waiver of any other remedy.

8.6. State May Cure Service Provider Defaults

If Service Provider commits an "Event of Default" in the performance of any term, provision, covenant or condition on its part to be performed hereunder, the Department may, upon notice to Service Provider after the expiration of any curative periods for which provision is made in this Contract, perform the same for the account and at the reasonable expense of Service Provider. If, at any time and by reason of such default, the Department is compelled to pay, or elects to pay, any sum of money or do any act which will require the payment of any sum of money, or is compelled to incur any expense in the enforcement of its rights hereunder or otherwise, such sum or sums, with a rate of interest if not established herein then as statutorily set by the State Comptroller (or successor), which together will be repaid to the Department by Service Provider promptly when billed therefor.

SECTION 9: DISPUTE RESOLUTION

9.1. Overview

Dispute Resolution and Mediation Procedure: Any conflict or dispute between the Department and the Service Provider relating to the Contract will be resolved in accordance with the procedures specified in this Contract, which will be the sole and exclusive procedures for the resolution of any such disputes prior to litigation. Negotiations and Mediation as herein prescribed is a precondition to litigation; however, this Section 9 will not apply in the case of Termination for Convenience as provided in Section 2.1.3 of this Contract.

9.2. Informal Negotiations/Informal Resolution

Whenever the Department and Service Provider have a dispute relative to the Contract, the managers will immediately attempt to resolve the dispute, subject to the approval of the authorized signatory of the Parties or their designees.

9.3. Informal Executive Level Negotiations

Service Provider and the Department will attempt in good faith to resolve any dispute arising out of or relating to the Contract promptly by negotiation between the Secretary of the

Department and an executive of the Service Provider or their designees having authority to settle the controversy, and who are at a higher level of management than persons with direct responsibility for the administration of the services at issue.

9.4. Mediation

If the Department and Service Provider are not able to resolve a dispute by negotiation, the Department, in its sole discretion, may initiate a mediation proceeding by a request in writing to the Service Provider within five (5) business days after delivery of the notice declaring the negotiation process terminated as required by the Dispute Resolution section. The mediation, if initiated by the Department, is a condition precedent to filing any civil action against any Party.

9.4.1 Mediation Procedure. All mediation proceedings will be conducted in accordance with the Contract and Florida Statutes.

9.4.2 Selection of a Neutral Mediator. If the Department and Service Provider have not agreed within ten (10) business days of the request for mediation on the selection of a neutral mediator willing to serve, then the Department will unilaterally select the mediator, who must be a Florida lawyer resident in Tallahassee, Florida. The mediator cannot be anyone directly employed by the State of Florida.

9.4.3 Location of Mediation. Unless otherwise agreed in writing by the Department and Service Provider, mediation sessions will occur in Tallahassee, Florida.

9.4.4 Mediation Period. Mediation pursuant to this Mediation section will be conducted over a period of forty-five (45) calendar days following the appointment of a mediator. If the dispute cannot be resolved by the mediation deadline, or by the end of any mutually agreed continuation thereof, either (i) the Department, (ii) the Service Provider or (iii) the mediator may give written notice declaring the mediation process terminated.

9.5 Obligation to Mediate

Parties regard the obligation to mediate as an essential provision of the Contract and one that is legally binding on each of them. In case of a violation of such obligation by either Party, the other may being an action to seek enforcement or such obligation in any court of law having jurisdiction thereof. Further, the Party at fault for failure to mediate will forfeit its right to any private cause of action.

9.6 Performance to Continue

Each Party will continue to perform its obligations under this Contract pending final resolution of any dispute arising out of this Contract.

9.7 Confidentiality

All negotiations and mediations will be treated as compromise and settlement negotiations and therefore confidential.

9.8 Notice of Decision

If the procedures outlined in the Negotiation and Mediation sections do not resolve the dispute, the dispute will be decided by the Secretary of the Department, who will reduce the decision to writing and serve a copy to the Service Provider. The decision of the Secretary will be final and conclusive, unless within ten (10) Calendar Days from the date of receipt, Service Provider files with the Department a petition for administrative hearing. The Department's decision on the petition will be final, subject to the Service Provider's right to review pursuant to Chapter 120 of the Florida Statutes. Exhaustion of administrative remedies is an absolute condition precedent to Service Provider's ability to pursue any other action.

9.9 Venue

Without limiting the foregoing, the exclusive venue for any legal or equitable action that arises out of or relates to the Contract will be the appropriate state court in Leon County, Florida; in any such action Florida law will apply and the parties waive any right to jury trial.

9.10 Payment of Fees and Costs

Except as provided by the indemnity clauses contained herein, the Department and Service Provider will each bear its own costs and legal expenses incurred in connection with any negotiations, mediation or litigation pursuant to this Contract. The Parties will equally share the cost of the mediator.

SECTION 10: TRANSITION

Upon the earlier of six (6) months before the expiration of the Contract or upon any notice of termination of the Contract, Service Provider will provide transition services to the Department without regard to the reason for termination. Transition services will be provided for up to twelve (12) months unless otherwise waived by the Department. Transition services will include: (i) continued provision of Services at the same terms, conditions and pricing in effect at the end of the Contract term until a succeeding vendor is prepared to provide all essential Services; (ii) Service Provider's cooperation with the Department, its consultant or designee and the succeeding vendor designated by the Department; (iii) notification of current procedures; (iv) listing of equipment and software licenses then used to provide the Services; (v) explanation of operations to new staff; (vi) submission of a schedule for transition activities; (vii) return of Department-owned materials being utilized by Service Provider; and (viii) in post migration status, answering reasonable questions on an as-needed basis.

For the transition services identified in items (ii) through (viii) above, the services will (a) be provided at no additional cost if the Contract expires or is terminated by the Department for cause, and (b) be provided at a reasonable, market-based rate if the Contract is terminated by the Department for convenience or by Service Provider for cause.

Service Provider recognizes that the Services are vital to the Department and must be continued without interruption and that, upon Contract expiration or termination, a successor may continue them. Service Provider's failure to cooperate in providing transition services is an

Event of Default that will entitle the Department to damages. Service Provider will continue to be subject to the performance standards and liquidated damages during transition of services and will provide experienced personnel throughout the transition period to ensure that the Services and the required service levels are maintained.

SECTION 11: GENERAL PROVISIONS

11.1. Advertising

Service Provider will not publicly disseminate any information concerning the Contract without prior written approval from the Department, including, but not limited to mentioning the Contract in a press release or other promotional material, identifying the Department or the State as a reference or otherwise linking Service Provider's name and either a description of the Contract or the name of the State or the Department in any material published, either in print or electronically, to anyone except Participants, network providers or potential or actual authorized Subcontractors. Within a reasonable time after the Effective Date, the Parties may issue a mutually agreeable joint press release regarding the Contract and the Services to be provided hereunder.

The Department will permit Service Provider to use its firm's logos, symbols, trademarks, trade names or service marks on Plan identification cards and other Department approved forms, and to promote Service Provider's relationship with the State to potential or existing network providers. Service Provider will not use the State of Florida seal, name or logo of the Division, Department or State, or Service Provider's relationship to the Plan, for any purpose without the prior written consent of the Department.

Service Provider will not publish or release the results of its engagement and participation in the Plan without prior written approval from the Department. However, Service Provider may refer to the contract as an experience citation with other customers without prior approval.

11.2. Assignment

Service Provider will not sell, assign or transfer any of its rights, duties or obligations under the Contract without the prior written consent of the Department. The Department may assign the Contract with prior written notice to Service Provider of its intent to do so. No change in Service Provider organization, if any, will operate to release the Service Provider from its liability for the prompt and effective performance of its obligations under this Contract.

11.3. Changes of Statute or Regulation or Governmental Restrictions

In the event Service Provider knows or should have known that any federal or state policies, operating procedures, laws, rules or regulations have been or will be changed, created or otherwise modified so as to materially change or impact, either directly or indirectly, the Services, the medical industry, the managed care industry, the pharmaceutical manufacturing industry or the responsibilities of the Parties (herein referred to as "Changes"), Service Provider will promptly notify the Department, indicating the specific law, rule, regulation, draft or pending legislation and/or policies and procedures.

Service Provider will implement all requirements arising from Changes and the Parties will modify this Contract to the extent reasonably necessary to ensure that the Services will be in full compliance with such Changes. Such compliance will not entitle Service Provider to any extension of time, term or increase in compensation, except for those Changes that materially cause an increase in the Services or the Scope of Work. The Department reserves the right and the complete discretion to accept any such alteration or to cancel the Contract at no further expense to the Service Provider.

Service Provider will not be entitled to an equitable adjustment for any Changes made to the Benefits Document, the Plan or Chapter 60A-1 of the Florida Administrative Code, even if such Changes are attributable directly or indirectly to a state statute, law or other any action by Florida Legislature which is intended to modify the Plan, the Benefits Document, the State Group Insurance Program or the Prescription Drug Program.

11.4. Compliance with Laws

(a) Generally: Service Provider will comply with all laws, rules, codes, ordinances, and licensing requirements that are applicable to the conduct of its business, including those of federal, State and local agencies having jurisdiction and authority. By way of non-exhaustive example, Chapter 287 of the Florida Statutes and Chapter 60A-1 of the Florida Administrative Code govern the Contract. Violation of any such laws will be grounds for Contract termination.

(b) Anti-Kickback Statute: Each party certifies that it will not violate the federal anti-kickback statute, set forth at 42 U.S.C§ 1320a-7b(b) ("Anti-Kickback Statute"), or the federal "Stark Law," set forth at 42 U.S.C. § 1395nn ("Stark Law"), with respect to the performance of its obligations under this Contract.

(c) Compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA): Service Provider will comply with HIPAA, as amended, and its rules and regulations, including but not limited to the provisions governing the privacy and security of records as well as administrative simplification. Service Provider will assist the State in implementing its compliance with this legislation as it relates to employee health benefits including but not limited to the Combined HIPAA Privacy Business Associate Agreement and Confidentiality Agreement and HIPAA Security Rule Addendum and HI-TECH Act Compliance Agreement, attached hereto as Exhibit C. Regarding services delivered under this contract, Service Provider's subcontracts will incorporate language that requires those Subcontractors to satisfy HIPAA requirements.

(d) Public Entity Crimes: A person or affiliate who has been placed on the convicted vendor list following a conviction for a public entity crime, as defined in section 287.133(1)(g), Florida Statutes, may not submit a bid or proposal on a contract to provide any goods or services to a public entity, may not submit a bid or proposal on a contract with a public entity for the construction or repair of a public building or public work, may not submit bids or proposals on leases of real property to a public entity, may not be awarded or perform work as a Service Provider, supplier, Subcontractor, or consultant under a contract with any public entity, and may not transact business with any public entity in excess of the threshold amount provided in

Section 287.017, Florida Statutes, for Category Two for a period of 36 months from the date of being placed on the convicted vendor list.

(e) Internal Revenue Service Reporting: Service Provider will make all necessary reports to the Internal Revenue Service regarding benefit payments made to health care Service Providers as required by law.

(f) Equal Employment Opportunity: Service Provider will not discriminate in its employment practices based on race, color, religion, age, sex, marital status, political affiliation, national origin or handicap, except as provided by law.

(g) Notice to the Department of Changes: In the event Service Provider becomes aware that any federal or state policies, operating procedures, laws, rules, or regulations applicable to this Contract have been or will be changed, created or otherwise modified so as to material change or impact, either directly or indirectly, the Plan, this Contract, the health industry or the responsibilities of the Parties hereunder, Service Provider will immediately notify the Department, indicating the specific law, rule, regulation, draft or pending legislation, and/or policies and procedures. The Parties may renegotiate the relevant portions of the Contract necessary to preserve compliance and the original intent of the Parties, to the extent permitted by law.

11.5. Contract Administrator

The Department will name a Contract Administrator during the Term of this Contract whose responsibility will be to maintain this Contract. As of the Effective Date, the Contract Administrator is Lori Anderson, 4050 Esplanade Way, Suite 380, Tallahassee, FL 32399. The Department will provide written notice to Service Provider of any changes to the Contract Administrator; provided, such changes will not be deemed Contract amendments.

11.6. Execution in Counterparts

The Contract may be executed in counterparts, each of which will be an original and all of which will constitute but one and the same instrument.

11.7. Best Pricing

Service Provider acknowledges and recognizes that the State wants to take advantage of any improvements in pricing/fees over the course of the Contract period. To that end, the pricing indicated in this Contract is a maximum guarantee.

Service Provider's ASO fee under this Contract will not exceed Service Provider's total ASO fees then in effect for substantially the same services to any organization with enrollment equal to or less than the Service Provider's Subscriber count at the relevant time. During the term of the Contract, if Service Provider implements or provides any other client, whether a public or private entity, with fewer enrollees such pricing with an ASO fee more favorable than the pricing in this Contract, then Service Provider agrees to offer equivalent pricing terms to the Department and the Department and Service Provider will execute a amendment of this Contract.

11.8. Force Majeure, Notice of Delay and No Damages for Delay

Service Provider will not be responsible for delay resulting from its failure to perform if neither the fault nor the negligence of Service Provider or its employees or agents contributed to the delay and the delay is due directly to acts of God, wars, acts of public enemies, strikes, fires, floods, or other similar cause wholly beyond Service Provider's control, or for any of the foregoing that affect Subcontractors or suppliers if no alternate source of supply is available to Service Provider. In case of any delay Service Provider believes is excusable, Service Provider will promptly notify the Department in writing of the delay or potential delay and describe the cause of the delay. The Department will then provide a reasonable extension in time for Service Provider to perform. **THE FOREGOING WILL CONSTITUTE SERVICE PROVIDER'S SOLE REMEDY OR EXCUSE WITH RESPECT TO DELAY.** Providing notice in strict accordance with this paragraph is a condition precedent to such remedy. No claim for damages, other than for an extension of time, will be asserted against the Department. Service Provider will not be entitled to an increase in the Contract price or payment of any kind from the Department for direct, indirect, consequential, impact or other costs, expenses or damages, including but not limited to costs of acceleration or inefficiency, arising because of delay, disruption, interference or hindrance from any cause whatsoever. Notwithstanding anything to the contrary herein, if the Department determines, in its sole discretion, that the delay will significantly impair the value of the Contract to the State, in which case the Department may (1) accept allocated performance from Service Provider, provided that Service Provider grants preferential treatment to the Department with respect to Services subjected to allocation, and/or (2) purchase from other sources (without recourse to and by Service Provider for the related costs and expenses) to replace all or part of the Services that are the subject of the delay, which purchases may be deducted from the Contract quantity, or (3) terminate the Contract in whole or in part.

11.9. Further Assurances

The Parties will, subsequent to the Effective Date, and without any additional consideration, execute and deliver any further legal instruments and perform any acts that are or may become necessary to effectuate the purposes of the Contract.

11.10. Indemnification

As required by Section 110.123(5)(f), Florida Statutes, Service Provider will indemnify, defend and save harmless the State and Plan Subscribers, for any financial loss caused by the failure of the Service Provider, its officers, directors or agents to comply with the terms of this Contract. Service Provider will indemnify, defend and hold harmless the Department from and against any third party claims, demands, loss, damage or expense relating to bodily injury or death of any person or damage to real and/or tangible personal property directly caused by Service Provider and/or its employees, in connection with the performance of the Services hereunder.

11.11. Independent Contractor Status of Service Provider

Service Provider, together with its agents, Subcontractor, officers and employees, will have and always retain under the Contract the legal status of an independent contractor, and in no manner will they be deemed employees of the Department or deemed to be entitled to any

benefits associated with such employment. During the term of the Contract, Service Provider will maintain at its sole expense those benefits to which its employees would otherwise be entitled to by law, including health benefits, and all necessary insurance for its employees, including workers' compensation, disability and unemployment insurance, and provide the Department with certification of such insurance upon request. Service Provider remains responsible for all applicable federal, state and local taxes, and all FICA contributions. Each party to the contract is considered an independent contractor and as such will not have any authority to bind or commit the other. Nothing herein will be deemed or construed to create a joint venture, partnership or agency relationship between the parties for any purpose.

11.12. Entire Agreement; Modification of Terms

(a) The Contract contains all the terms and conditions agreed upon by the parties, which terms and conditions will govern all transactions under the Contract. Modification of the Contract terms, including increases or changes to contracted rates, fees, rebates, discounts, the total amount of the contract, or other change to terms and conditions will require a mutual written amendment to the contract, signed by both parties.

(b) No oral contracts or representations will be valid or binding upon the Department or Service Provider. Service Provider may not unilaterally modify the terms of the Contract by incorporating terms onto Service Provider's order or fiscal forms or other documents forwarded by Service Provider for payment. The Department's acceptance of service or processing of documentation on forms furnished by Service Provider for approval or payment will not constitute acceptance of the proposed modification to terms and conditions.

11.13. Notices and Administrative and Legal Proceedings

11.13.1 Legal Actions

(a) Notice of Legal Actions or Proceedings: Service Provider will promptly notify the Department of any Plan-related legal actions or proceedings brought or initiated against Service Provider, the Department, the State, or the Plan, of which Service Provider becomes aware. The Department will promptly notify Service Provider of any Plan-related legal actions or proceedings, brought or initiated against Service Provider, the Department, the State, or the Plan, of which the Department becomes aware. Any Plan-related legal proceedings against the Department relating to or arising out of the Contract over which Service Provider has control will be brought in the appropriate state or federal administrative or judicial forum, with exclusive venue in Leon County, Florida.

1. Department As Real Party In Interest: Except as specified below, where a Plan Participant or a service provider files a lawsuit or initiates a legal proceeding concerning Plan eligibility, enrollment, coverage, benefits or the interpretation of the Benefits Document, Service Provider may defend itself by filing such motions as it deems appropriate, including but not limited to the filing of a motion to drop Service Provider from the lawsuit and/or to substitute the Department as the Real Party in interest, if appropriate.

2. Notice by Service Provider of Motion: Service Provider will, when possible, notify

the Department prior to the filing of any motion specified above or, if notification was not possible prior to the filing of such motion, no later than 7 business days after the filing of any such motion. If a Plan Participant files suit against Service Provider without previously requesting an administrative hearing pursuant to Chapter 120, Florida Statutes, Service Provider will file a motion to dismiss or file any appropriate motions and will notify the Department of its action. Prior to filing any such motions, Service Provider will, when possible, advise the party filing the suit, as appropriate, that the Plan requires the exhaustion of administrative remedies and/or that the real party in interest is the Department. The Department may support Service Provider's motions, as specified in this subsection, to drop Service Provider and/or to substitute the Department, if the Department is not already a party to the lawsuit, as the real party in interest when requested by Service Provider. If the Department is a co-defendant in any such lawsuit, the Department may support any appropriate motion(s) to drop Service Provider from the lawsuit.

3. Service Provider As Real Party In Interest: In the event a lawsuit is filed against Service Provider which raises a Florida recognized cause of action or Claim for relief based on Service Provider's application of its own policies or procedures to the administration of the Plan, Service Provider will, at its expense, defend such lawsuit provided, however, that the Department did not specifically authorize or approve the policy or procedure at issue in the lawsuit, Service Provider will support the Department in any motion filed to drop the Department from any lawsuit where the damages sought by the filing litigant allegedly arise out of policies and procedures of Service Provider which were not authorized or approved by the Department and which do not concern Plan eligibility, enrollment, coverage, benefits or the interpretation of the Benefits Document.

(b) Cooperation in the Defense of Administrative and/or Legal Actions: The Parties will, upon request, cooperate fully with each other concerning any administrative or legal proceeding, brought or initiated against them individually or jointly by Plan Participants, providers of health care or other persons relating to the administration of the Plan. In this regard, the Parties will use their best efforts to keep each other apprised of any significant developments relating to such litigation or proceedings and the status of such legal matters as may be requested by their respective attorneys. In all administrative or legal proceedings, Service Provider will make available all files and documents requested by Department and Service Provider attorneys, investigate the facts related to allegations raised in the proceedings and make available as required by the Department and at no additional cost, witnesses for depositions, administrative hearings and/or trial in any such proceedings.

(c) Administrative Proceedings: The Department, as an agency of the State of Florida, will be responsible, in accordance with State Law, for handling and defending any administrative actions or proceedings brought by Plan Participants in accordance with Sections 120.569, 120.57 or 120.574, Florida Statutes. Upon request, Service Provider will promptly provide the Department with all records, including but not limited to, materials, available data, schedules, guidelines, audit trail, protocols or other materials that are necessary for the preparation of the defense in such proceedings.

(d) Support and Communication with Service Provider's Legal Affairs Department: Service Provider will, upon request of the Department, assist attorneys representing the Department by providing information and support in administrative and legal proceedings being contested by Plan Participants. Service Provider will advise the Department in writing within thirty (30) days after the Effective Date of the representative who will assist the Department's attorneys.

11.13.2 Notices

(a) All notices under this Contract will be served upon the Department by certified mail, return receipt requested, by reputable courier service or delivered personally to each of the following:

Department of Management Services
Contract Administrator, Departmental Purchasing
4050 Esplanade Way, Suite 380
Tallahassee, FL 32399-0950

Department of Management Services
Office of the Secretary
4050 Esplanade Way, Suite 280
Tallahassee, FL 32399

Department of Management Services
Office of the General Counsel
4050 Esplanade Way, Suite 160
Tallahassee, FL 32399-0950

(b) All notices under this Contract to be served upon Service Provider will be served by certified mail, return receipt requested, by reputable courier service or delivered personally to:

Jon Urbanek

4800 Deerwood Campus Parkway, DCC1-8

Jacksonville, Florida 32246

With a copy to:

Richard Beeman

4800 Deerwood Campus Parkway, DCC8-5

Jacksonville, Florida 32246

(c) The Parties agree that any change in the above-referenced address or name of the contact person will be submitted in a timely manner to the other Party. All notices and other communications under this Contract will be in writing and will be deemed duly given either: (i) when delivered in person to the recipient named above; (ii) upon confirmation of courier

delivery to the intended recipient; or (iii) three (3) business days after mailed by certified U.S. mail, return receipt requested, postage prepaid, addressed by name and address to the Party intended.

11.14. Contract Managers

Each Party will designate a Contract Manager during the Term of this Contract whose responsibility will be to oversee the Party's performance of its duties and obligations pursuant to the terms of this Contract. As of the Effective Date, the Department's Contract Manager is Dee Fort, PPO Plan Manager, 4050 Esplanade Way, Suite 215, Tallahassee, FL 32399-0950. Service Provider's Contract Manager is Richard Beeman, at 4800 Deerwood Campus Parkway, Jacksonville, Florida 32246. Each Party will provide prompt written notice no later than five (5) business days to the other Party of any changes to the Party's Contract Manager or his or her contact information. Such changes will not be deemed Contract amendments.

11.15. Public Records

Any and all records produced or used regarding this Contract are subject to Chapter 119 of the Florida Statutes. Absent a valid exemption, Service Provider will allow public access to all documents, papers, letters, or other material subject to Chapter 119 that are made or received by Service Provider in conjunction with this Contract. Pursuant to section 119.0701, the Service Provider will:

(a) Keep and maintain public records that ordinarily and necessarily would be required by the Department in order to perform the Services;

(b) Provide the public with access to public records on the same terms and conditions that the Department would provide the records and at a cost that does not exceed the cost provided in this chapter or as otherwise provided by law;

(c) Ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law;

(d) Meet all requirements for retaining public records and transfer, at no cost, to the Department all public records in possession of the contractor upon termination of the contract and destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. All records stored electronically must be provided to the Department in a format that is compatible with the information technology systems of the public agency.

Violation of this section will constitute grounds for termination of the Contract at the discretion of the Department.

If Service Provider considers any portion of a public record to be confidential, trade secret or otherwise not subject to disclosure pursuant to Chapter 119, Florida Statutes, the Florida Constitution or other authority, Service Provider will upon request provide the Department with a separate redacted version of the record and briefly describe in writing the grounds for

claiming exemption from the public records law, including the specific statutory citation for such exemption. This redacted copy will be clearly titled "Redacted Copy."

The Redacted Copy must only exclude or obliterate those exact portions which are claimed confidential, proprietary or trade secret. Service Provider will be responsible for defending its determination that the redacted portions are confidential, trade secret or otherwise not subject to disclosure. Further, Service Provider will protect, defend and indemnify the Department for any and all claims arising from or relating to the determination that the redacted portions are confidential, proprietary, trade secret or otherwise not subject to disclosure. If Service Provider fails to submit a Redacted Copy to the Department, the Department is authorized to produce the entire documents, data or records in answer to a public records request for these records.

11.16. Security and Confidentiality

In the event of loss of any State data or record or breach of security by Service Provider or any of its Subcontractors or agents, Service Provider will immediately notify the Department by phone or e-mail. Service Provider will be responsible for recreating or retrieving such lost data in the manner and on the schedule set by the Department.

11.17. Waiver

No covenant, condition, duty, obligation or undertaking contained in or made a part of the Contract may be waived except by the written Contract of the parties; and a forbearance or indulgence in any other form or manner by either party in any regard whatsoever will not constitute a waiver of the covenant, condition, duty, obligation or undertaking to be kept, performed or discharged by the party to which the same may apply.

The delay or failure by a Party to exercise or enforce any of its rights under this Contract will not constitute or be deemed a waiver of the Party's right thereafter to enforce those rights, nor will any single or partial exercise of any such right preclude any other or further exercise thereof or the exercise of any other right.

11.18. Rights to Intellectual Property

Unless otherwise agreed in writing, (i) intellectual property rights to property existing prior to this Contract will remain with Service Provider and (ii) intellectual property rights to all property created or otherwise developed by Service Provider specifically for the Department will be owned by the Department and the State of Florida.

No Proprietary Interest: Service Provider will not have and will obtain no proprietary interest in any patient records, Plan-related data, data files, documents, papers, records and other Plan information, in any form created, that it acquires in the course of its performance under the Contract; provided, however, that the Service Provider's names, logos, trademarks, trade names, service marks and trade secret information are not subject to this provision.

11.19. Survival Clause

All provisions in the Contract that expressly or customarily survive the termination or expiration of the Contract will continue in effect after the Contract is terminated or expires.

11.20. Organizational Conflicts of Interest

Service Provider has disclosed the names and specific services in which it has participated in preparing any business cases, drafting of solicitations, or development of any programs for future implementation by the Department. Service Provider therefore warrants that no such organizational conflicts of interest exist.

11.21. Service Provider's Brands and Disclosure

The names, logos, symbols, trademarks, tradenames, and service marks of Service Provider, whether presently existing or hereafter established, are the sole property of Service Provider. The names, logos, symbols, trademarks, tradenames, and service marks of the Blue Cross and Blue Shield Association, whether presently existing or hereafter established, are the sole property of the Blue Cross and Blue Shield Association. Service provider and the Blue Cross and Blue Shield Association retain their respective rights to the use and control of any such names, logos, trademarks, tradenames, and service marks. The Department shall not use Service Provider's or the Blue Cross and Blue Shield Association's name, logos, symbols, trademarks or service marks in advertising or promotional materials without the prior written consent of Service Provider or the Blue Cross and Blue Shield Association and shall cease any such usage immediately upon written notice by Service Provider or the Blue Cross and Blue Shield Association or upon termination of this Contract, whichever is sooner. Further the Department hereby expressly acknowledges its understanding that this Contract constitutes a contract solely between the Department and Service Provider, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting Service Provider to use the Blue Cross and/or Blue Shield Service Marks in Florida, and that Service Provider is not contracting as the agent of the Association. The Department further acknowledges that it has not entered this Contract based on the representations of any person other than the Service Provider, and that the Blue Cross and Blue Shield Association is not liable to the Department or any Participant for Service Provider's obligations under this Contract

11.22 Participating Providers Under the Out-of-State BlueCard® Program

Participants, when accessing care outside Florida, may obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographical area ("Host Plan"). Service Provider's payment practices in such instances under this Contract are described below. Under the BlueCard® Program, when Participants access Covered Services within the geographic area served by a Host Plan, Service Provider will remain fully responsible to the Department for fulfilling all of Service Provider's obligations under this Contract and Host Plans are not Subcontractors under this Contract. However, in accordance with applicable BlueCard® Program policies then in effect, the applicable Host Plan will be responsible for providing those

services which are then the obligations of Host Plans (e.g., contracting and handling substantially all interactions with its participating healthcare providers). The financial terms of the BlueCard® Program are described generally below. All Home and Host Plans are required to participate in the BlueCard® Program and to follow all applicable BlueCard® policies then in effect.

(a) Liability Calculation Method Per Claim

The calculation of the Participant liability on claims for Covered Services processed through the BlueCard® Program will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to Service Provider by the Host Plan.

The calculation of the Department's liability on claims for Covered Services processed through the BlueCard® Program will be based on the negotiated price made available to Service Provider by the Host Plan. This negotiated price may be greater than what would be the healthcare provider(s)' billed charges in those instances where the Host Plan has negotiated with its participating healthcare provider(s) an inclusive allowance for specific healthcare services (e.g., DRG or per case or per day amount payment methodologies).

Each Host Plan's determination of an applicable negotiated price will be consistent with the terms of each Host Plan's applicable healthcare provider contract. The negotiated price made available to Service Provider by the Host Plan which will be passed through to the Department under this Contract is one of the following:

(i) an actual price. An actual price is a negotiated payment without any other increases or decreases, or

(ii) an estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives, or

(iii) an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Plan with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the examples noted above for an estimated price.

Host Plans using either an estimated price or an average price may, in accordance with BlueCard® policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Participant and the Department is a final price for the limited

purpose of pricing an applicable claim and no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard® Program specifically requires that the price submitted by a Host Plan to Service Provider is a final price under this Contract for the limited purpose of pricing an applicable claim and irrespective of any future adjustments based on the use of estimated or average pricing. Recovery of overpayments from a Host Plan or its participating healthcare providers will in any event be applied for the benefit of the Department independent of this limited pricing rule and consistent with terms of this Contract.

If a Host Plan uses either an estimated price or an average price on a claim, it may also hold some portion of the amount paid by a Home Plan in a variance account, pending settlement with its participating healthcare providers. This includes amounts paid by Service Provider as a Home Plan which are passed through to the Department under this Contract. Because all such amounts paid are final for the limited purpose of pricing an applicable claim, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from the Department. Such payable or receivable funds would be eventually exhausted by healthcare provider settlements and/or through prospective adjustment to the negotiated prices. *In such instances some Host Plans may retain interest earned, if any, on funds held in variance accounts.*

In some instances federal law or the laws of a small number of states may require Host Plans either (i) to use a basis for determining Participant liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should either federal law or the law of the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, an applicable Host Plan would then calculate both Participant liability and Service Provider liability for Covered Services which are passed through to the Department under this Contract in accordance with such applicable law.

(b) Return of Overpayments

Under the BlueCard® Program, recoveries from a Host Plan or its participating healthcare providers include, but are not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, a Host Plan may engage a third party to assist in identification or collection of recovery amounts. All recovery amounts will be applied in accordance with applicable BlueCard® Program policies (which generally require correction on a claim-by-claim or prospective basis) and consistent with terms of this Contract.

(c) BlueCard® Program Fees

The Department will, under this Contract, reimburse Service Provider for access fees which the Service Provider, as a Home Plan, is obligated under the BlueCard® Program to pay to the Host Plans and to the Blue Cross and Blue Shield Association (BCBSA) as described below. Such access fees under the BlueCard® Program may be revised in accordance with the Program's standard procedures for revising such fees, which do not provide for prior approval by any accounts/groups, including the Department.

These access fees are charged each time a claim is processed through the BlueCard® Program and an access fee will be passed on to the Department as an additional claim liability. It will be a percentage of the discount/differential Service Provider receives from the applicable Host Plan, based on the current rate in accordance with the Program's standard procedures for establishing the access fee rate. The access fee will not exceed $2,000 for any claim.

11.23 Non-Participating Providers Under the Out-of-State BlueCard® Program

In some instances, Participants, when accessing care outside Florida, may obtain care from healthcare providers that do not have a contractual agreement with a Host Plan (i.e., are non-participating providers). Service Provider's payment practices in such instances under this Contract are described below:

(a) Participant Liability Calculation

When Covered Services are provided outside of Florida by non-participating healthcare providers, the amount a Participant pays for such services will generally be based on either the Host Plan's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the Participant may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment Service Provider will make for the Covered Services as set forth in this paragraph.

(b) Fees

Fees for Covered Services provided by non-participating providers under the BlueCard® Program may be revised in accordance with the Program's standard procedures for revising such fees, which do not provide for prior approval by any accounts/groups, including the Department. However, while Service Provider must pay an administrative fee to the Host Plan, it is specifically agreed that in this regard no fees of any kind will be passed through to the Department under this Contract and that Department will not reimburse Service Provider for any such fees.

SO AGREED:

STATE OF FLORIDA
DEPARTMENT OF MANAGEMENT SERVICES

By: _____

Name (Printed): C. DARREN BROOKS

Title: Deputy Secretary, Workforce Operations

Date: 3/19/2014

BLUE CROSS ANDBLUE SHIELD OF FLORIDA, INC. (D/B/A, FLORIDA BLUE)

By: _____

Name (Printed): JON URBANEK

Title: SVP, Health Insurance Markets

Date: 3/18/2014

COMBINED HIPAA PRIVACY BUSINESS ASSOCIATE AGREEMENT
AND CONFIDENTIALITY AGREEMENT
AND HIPAA SECURITY RULE ADDENDUM
AND HITECH ACT COMPLIANCE AGREEMENT

The terms of this agreement may be updated from time to time to reflect changes in related federal standards.

The Parties have entered into this Agreement for the purpose of satisfying the Business Associate contract requirements of the regulations at 45 CFR 164.502(e) and 164.504(e), issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Security Rule, codified at 45 C.F.R Part 164, Subparts A and C. (the "Security Rule"), the Health Information Technology For Economic and Clinical Health Act, enacted in Pub. L. No. 111-05 H.R., 111th Cong. (2009), Title XIII (the "HITECH Act"), as well as the confidentiality requirements contained in section 110.123 (9), Florida Statutes.

The Parties: The Florida Department of Management Services, Division of State Group Insurance (the "Covered Entity").

Blue Cross and Blue Shield of Florida, Inc., with its principal place of business at 4800 Deerwood Campus Parkway, Jacksonville, Florida 32246 (the "Business Associate").

1.0 Definitions

Terms used but not otherwise defined in this Agreement will have the same meaning as those terms in 45 CFR 160.103 and 164.501, and in the HITECH Act, Subtitle D.

"Individual" has the same meaning as the term "individual" in 45 CFR 164.501 and will include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

"Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

"Protected Health Information" is defined at 45 CFR 160.103 and in the HITECH Act. For purposes of this Agreement, the term refers only to that Protected Health Information received directly or indirectly from, or received or created on behalf of, the Covered Entity.

"Secretary" means the Secretary of the U.S. Department of Health and Human Services or designee.

"Security Incident" means any event resulting in computer systems, networks, or data being viewed, manipulated, damaged, destroyed or made inaccessible by an unauthorized activity. See National Institute of Standards and Technology (NIST) Special Publication 800-61, "Computer Security Incident Handling Guide," for more information.

2.0 Obligations and Activities of Business Associate Regarding Protected Health Information

(a) Business Associate agrees to not use or further disclose Protected Health Information other than as permitted or required by Sections 3.0, 5.0 and 6.0 of this Agreement, or as required by applicable federal or laws of the State of Florida.

(b) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

(c) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

(d) Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.

(e) Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

(f) Business Associate agrees to provide access, at the request of Covered Entity or an Individual, and in a prompt and reasonable manner consistent with the HIPAA regulations, to Protected Health Information in a designated record set, to the Covered Entity or directly to an Individual in order to meet the requirements under 45 CFR 164.524.

(g) Business Associate agrees to make any Amendment(s) to Protected Health Information in a designated record set that the Covered Entity or an Individual directs or agrees to pursuant to 45 CFR 164.526, in a prompt and reasonable manner consistent with the HIPAA regulations.

(h) Business Associate agrees to make its internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity available to the Covered Entity, or at the request of the Covered Entity, to the Secretary in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

(i) Business Associate agrees to document disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

(j) Business Associate agrees to provide to Covered Entity or an Individual an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528, in a prompt and reasonable manner consistent with the HIPAA regulations.

(k) Business Associate certifies that it is in compliance with all applicable provisions of HIPAA standards for electronic transactions and code sets, also known as the Electronic Data

Interchange (EDI) Standards, at 45 CFR Part 162; and the Annual Guidance as issued by the Secretary pursuant to the HITECH Act, sec. 13401. Business Associate further agrees to ensure that any agent, including a subcontractor, that conducts standard transactions on its behalf, will comply with the EDI Standards and the Annual Guidance.

(l) Business Associate agrees to determine the Minimum Necessary type and amount of Protected Health Information required to perform its services and will comply with 45 CFR 164.502(b) and 514(d).

3.0 Permitted or Required Uses and Disclosures by Business Associate

(a) Except as expressly permitted in writing by the Covered Entity, Business Associate will not divulge, disclose, or communicate Protected Health Information to any third party for any purpose not in conformity with this Contract without prior written approval from the Covered Entity.

(b) Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide data aggregation services to Covered Entity as permitted by 45 CFR 164.504(e)(2)(i)(B).

(c) Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR 164.502(j) (1).

(d) Business Associate may use Protected Health Information as necessary to provide the services required under the following service contract(s) with the Covered Entity: State of Florida PPO Third Party Administrative Services Contract dated of Contract].

4.0 Obligations of Covered Entity to Inform Business Associate of Covered Entity's Privacy Practices, and any Authorization or Restrictions.

(a) Covered Entity will provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 CFR 164.520, as well as any changes to such notice.

(b) Covered Entity will provide Business Associate with any changes in, or revocation of, Authorization by Individual or his or her personal representative to use or disclose Protected Health Information, if such changes affect Business Associate's uses or disclosures of Protected Health Information.

(c) Covered Entity will notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR 164.522, if such changes affect Business Associate's uses or disclosures of Protected Health Information.

5.0 Confidentiality Agreement Under State Law

(a) Generally. In addition to the HIPAA privacy requirements, Business Associate agrees to observe the confidentiality requirements of section 110.123 (9), Florida Statutes. In

general, the referenced statute provides that patient medical records and medical claims records of state employees, former state employees, and their covered dependents are confidential and exempt from the provisions of section 119.07 (1), Florida Statutes, known as the public records law of the State of Florida. Any person who willfully, knowingly, and without authorization discloses or takes data, programs, or supporting documentation, including those residing or existing internal and external to the Covered Entity's computer system, commits an offense in violation of section 815.04, Florida Statutes.

Confidentiality requirements protect more than unlawful disclosure of documents. The confidentiality requirements protect the disclosure of all records and information of the Covered Entity, in whatever form, including the copying or verbally relaying of confidential information.

(b) Receipt of a Subpoena. If Business Associate is served with subpoena requiring the production of the Covered Entity's records or information, Business Associate will immediately contact the Department of Management Services, Office of the General Counsel, (850) 487-1082.

A subpoena is an official summons issued by a court or an administrative tribunal, which requires the recipient to do one or more of the following:

i. Appear at a deposition to give sworn testimony, and may also require that certain records be brought to be examined as evidence.

ii. Appear at a hearing or trial to give evidence as a witness, and may also require that certain records be brought to be examined as evidence.

iii. Furnish certain records for examination, by mail or by hand-delivery.

(c) Employees and Agents. Business Associate acknowledges that the confidentiality requirements herein apply to all its employees, agents and representatives. Business Associate assumes responsibility and liability for any damages or claims, including state and federal administrative proceedings and sanctions, against the Covered Entity, including costs and attorneys' fees, resulting from the breach by Business Associate of the confidentiality requirements of this Agreement.

6.0 Permissible Requests by Covered Entity

Covered Entity will not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under HIPAA, the Privacy Rule, the HITECH Act, of the laws of the State of Florida, if done by Covered Entity.

7.0 Term and Termination

(a) Term. The Term of this Agreement will begin on the last date set forth on the signature blocks below and will terminate on the date the Business Associate no longer provides services to the Covered Entity.

(b) Termination for Cause. Without limiting any other termination rights the parties may have, upon Covered Entity's knowledge of a material breach by Business Associate of a provision under this Agreement, Covered Entity will provide an opportunity for Business Associate to cure the breach or end the violation. If the Agreement of Business Associate does not cure the breach or end the violation within the time specified by Covered Entity, the Covered Entity will have the right to immediately terminate the Agreement. If neither termination nor cure is feasible, Covered Entity will report the violation to the Secretary.

(c) Return or Destruction of PHI upon Termination. Within sixty (60) days after termination of the Agreement for any reason, or within such other time period as mutually agreed upon in writing by the parties, Business Associate will return to Covered Entity or destroy all Protected Health Information maintained by Business Associate in any form and will retain no copies thereof. Business Associate also will recover, and will return or destroy with such time period, any Protected Health Information in the possession of its subcontractors or agents. Within fifteen (15) days after termination of the Agreement for any reason, Business Associate will notify Covered Entity in writing as to whether Business Associate intends to return or destroy such Protected Health Information. If Business Associate elects to destroy such Protected Health Information, it will certify to Covered Entity in writing when and that such Protected Health Information has been destroyed. If any subcontractors or agents of the Business Associate elect to destroy the Protected Health Information, Business Associate will require such subcontractors or agents to certify to Business Associate and to Covered Entity in writing when such Protected Health Information has been destroyed. If it is not feasible for Business Associate to return or destroy any of said Protected Health Information, Business Associate will notify Covered Entity in writing that Business Associate has determined that it is not feasible to return or destroy the Protected Health Information and the specific reasons for such determination. Business Associate further agrees to extend any and all protections, limitations, and restrictions set forth in this Agreement to Business Associate's use or disclosure of any Protected Health Information retained after the termination of this Agreement, and to limit any further uses or disclosures to the purposes that make the return or destruction of the Protected Health Information not feasible. If it's not feasible for Business Associate to obtain, from a subcontractor or agent, any Protected Health Information in the possession of the subcontractor or agent, Business Associate will provide a written explanation to Covered Entity and require the subcontractors and agents to agree to extend any and all protections, limitations, and restrictions set forth in this Agreement to the subcontractors' or agents' uses or disclosures of any Protected Health Information retained after the termination of this Agreement, and to limit any further uses or disclosures to the purposes that make the return or destruction of the Protected Health Information not feasible.

Prior to destroying any records hereunder, the Business Associate will obtain written confirmation from the Covered Entity that such actions will not violate the State of Florida's record retention policies.

8.0 HIPAA Security Rule Addendum

(a) Security of Electronic Protected Health Information. Business Associate will develop, implement, maintain, and use administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information (as defined in 45 C.F.R. § 160.103) that Business Associate creates, receives, maintains, or transmits on behalf of the Covered Entity consistent with the Security Rule.

(b) Reporting Security Incidents. Business Associate will report to the Covered Entity any Security Incident of which Business Associate becomes aware that is (1) a successful unauthorized access, use or disclosure of any Electronic Protected Health Information; or (2) a successful major (a) modification or destruction of any Electronic Protected Health Information or (b) interference with system operations in an information system containing any Electronic Protected Health Information. Upon the Covered Entity's request, Business Associate will report any incident of which Business Associate becomes aware that is a successful minor (a) modification or destruction of any Electronic Protected Health Information or (b) interference with system operations in an information system containing any Electronic Protected Health Information.

(c) Compliance Date. The parties to this Amendment will comply with Sections (a) through (c) of this Section 8 by the later of the (1) the last date set forth in the signature blocks below or (2) the compliance deadline of the Security Rule as defined in 45 C.F.R. § 160.103.

9.0 HITECH Act Compliance Agreement

In the event of any inconsistency or conflict between Part II and Part III, the more stringent provision will apply.

(a) Reporting. The Business Associate will make a good faith effort to identify and report any use or disclosure of Protected Health Information not provided for in this Contract.

(c) To Covered Entity. The Business Associate will report to the Covered Entity, within ten (10) business days of discovery, any use or disclosure of Protected Health Information not provided for in this Contract of which the Business Associate is aware. The Business Associate will report to the Covered Entity, within twenty-four (24) hours of discovery, any Security Incident of which the Business Associate is aware. A violation of this paragraph will be a material violation of this Contract. Such notice will include the identification of each individual whose unsecured Protected Health Information has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, or disclosed during such breach.

(d) To Individuals. In the case of a breach of Protected Health Information discovered by the Business Associate, the Business Associate will first notify the Covered Entity of the pertinent details of the breach and upon prior approval of the Covered Entity will notify each individual whose unsecured Protected Health Information has been, or is reasonably believed by the Business Associate to have been, accessed, acquired or disclosed as a result of such breach. Such notification will be in writing by first-class mail to the individual (or the next of kin if the individual is deceased) at the last known address of the individual or next

of kin, respectively, or, if specified as a preference by the individual, by electronic mail. Where there is insufficient, or out-of-date contract information (including a phone number, email address, or any other form of appropriate communication) that precludes written (or, if specifically requested, electronic) notification to the individual, a substitute form of notice will be provided, including, in the case that there are 10 or more individuals for which there is insufficient or out-of-date contact information, a conspicuous posting on the Web site of the covered entity involved or notice in major print of broadcast media, including major media in the geographic areas where the individuals affected by the breach likely reside. In any case deemed by the Business Associate to require urgency because of possible imminent misuse of unsecured Protected Health Information, the Business Associate may also provide information to individuals by telephone or other means, as appropriate.

(e) To Media. In the case of a breach of Protected Health Information discovered by the Business Associate where the unsecured Protected Health Information of more than 500 persons is reasonably believed to have been, accessed, acquired, or disclosed, after prior approval by the Covered Entity, the Business Associate will provide notice to prominent media outlets serving the State or relevant portion of the State involved.

(f) To Secretary of Health and Human Services. The Business Associate will cooperate with the Covered Entity to provide notice to the Secretary of Health and Human Services of unsecured Protected Health Information that has been acquired or disclosed in a breach. If the breach was with respect to 500 or more individuals, such notice must be provided immediately. If the breach was with respect to less than 500 individuals, the Business Associate may maintain a log of such breach occurring and annually submit such log to the Covered Entity so that it may satisfy its obligation to notify the Secretary of Health and Human Services documenting such breaches occurring in the year involved.

(g) Content of Notices. All notices required under this Attachment will include the content set forth Section 13402(f), Title XIII of the American Recovery and Reinvestment Act of 2009.

(h) Financial Responsibility. The Business Associate will be responsible for all costs related to the notices required under this Attachment.

(i) Mitigation. Business Associate will mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a use or disclosure of Protected Health Information in violation of this Attachment.

10.0 Miscellaneous

(a) Regulatory References. A reference in this Agreement to a section in the Privacy Rule, the Security Rule or the HITECH Act means the section as in effect or as amended, and for which compliance is required.

(b) Amendment. Upon the enactment of any law or regulation affecting the use or disclosure of Protected Health Information, Standard Transactions, the security of Health Information, or other aspects of HIPAA-AS or the HITECH Act applicable or the publication of any decision of a

court of the United States or any state relating to any such law or the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of any such law or regulation, either party may, by written notice to the other party, amend this Agreement in such manner as such party determines necessary to comply with such law or regulation. If the other party disagrees with such Amendment, it will so notify the first party in writing within thirty (30) days of the notice. If the parties are unable to agree on an Amendment within thirty (30) days thereafter, then either of the parties may terminate the Agreement on thirty (30) days written notice to the other party.

(c) Survival. All provisions in this Agreement that expressly or customarily survive the termination or expiration of the Agreement will continue in effect after the Agreement is terminated or expires.

(d) Interpretation. Any ambiguity in this Agreement will be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy Rule and the confidentiality requirements of the State of Florida, including section 110.123 (9), Florida Statutes.

(e) No Third Party Beneficiary. Nothing expressed or implied in this Agreement is intended to confer, nor will anything herein confer, upon any person other than the parties and the respective successors or assignees of the parties, any rights, remedies, obligations, or liabilities whatsoever.

(f) Governing Law. This Agreement will be governed by and construed in accordance with the laws of the state of Florida to the extent not preempted by the Privacy Rules or other applicable federal law. In the event of a dispute, venue of any proceedings will be the appropriate federal or state court in Leon County, Florida.

(g) Indemnification and Performance Guarantees. Business Associate will indemnify, defend, and save harmless the State of Florida and Individuals for any financial loss as a result of claims brought by third parties and which are caused by the failure of Business Associate, its officers, directors or agents to comply with the terms of this Agreement.

(h) Assignment. Business Associate will not assign either its obligations or benefits under this Agreement without the expressed written consent of the Covered Entity, which will be at the sole discretion of the Covered Entity. Given the nature of this Agreement, neither subcontracting nor assignment by the Business Associate is anticipated and the use of those terms herein does not indicted that permission to assign or subcontract has been granted.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the Parties have executed this combined HIPAA Privacy Business Associate Agreement, Confidentiality Agreement, HIPAA Security Rule Addendum and HITECH Act Compliance Agreement, on the date(s) set forth below.

STATE OF FLORIDA
DEPARTMENT OF MANAGEMENT SERVICES

By: _____

Name (Printed): C. DARREN BROOKS

Title: Deputy Secretary, Workforce Operations

Date: 3/19/2014

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC. (D/B/A, FLORIDA BLUE)

By: _____

Name (Printed): JON URBANEK

Title: SVP, Health Insurance Markets

Date: 3/19/2014

Third Party Administrator Services

Exhibit A: Minimum Service Requirements

Service Provider will comply with and provide the following Minimum Service Requirements, which have designated "AR" numbers. All references to "PGs" mean the Performance Guarantees of Exhibit B.

Service Requirements	
I. Implementation	
AR-1	The Service Provider shall submit the final Implementation Plan to the Department for approval not later than 10 business days following execution of the Contract. If the Implementation Plan is not determined by the Department to be sufficient, Service Provider will diligently work to deliver a final Implementation Plan satisfactory to the Department and recognizes that time is of the essence in completing an Implementation Plan. The Implementation Plan shall be based on the proposed implementation plan submitted by the Service Provider during the procurement process. The Implementation Plan shall fully detail all steps necessary to begin full performance of the Contract on January 1, 2015, 12:00:00 A.M., specify expected dates of completion of all such steps, and identify the persons responsible for each step. The Implementation Plan shall include, but is not limited to, the following Implementation Milestones:
	◆ Establishing an interactive website exclusive for State of Florida Participants, exclusive toll-free phone line(s), and Department approved communications in advance of the fall 2014 Open Enrollment period.
	◆ Participating in the fall 2014 Open Enrollment benefit fairs and meetings coordinated by the Department.
	◆ Regular Implementation status meetings with the Department's Contract Manager. The Service Provider shall be responsible for recording detailed meeting minutes and follow up action items on behalf of all team members during implementation meetings.
	◆ Conducting background checks in accordance with Section 3.3.5 of the Contract.
	◆ Applying the provisions of the Benefits Document as the description of covered services, exclusions, limitations, etc.; establishing and successfully implementing any necessary edits, controls or other functions to ensure accurate Plan coverage for Participants.
	◆ Testing eligibility files, reviewing key procedures and program process controls (i.e. approval, design, testing, acceptance, user involvement, segregation of duties, and documentation). Functional acceptance approval by the Department is required.
	◆ Conducting a pre-implementation audit of approximately 200-300 manually created claims.

	◆ Finalize and validate billing procedures, invoice design, and other financial processes that must be approved by the Department.
	◆ Designing and presenting to the Department for approval all communication materials to be used for Plan Participants. Communication materials include but are not limited to ID Cards, brochures, explanation of benefit statement forms, paper claim (reimbursement) forms, Summary Plan Descriptions (SPDs), Summaries of Benefits and Coverage (SBCs), standard letters, system generated letters, templates, envelopes, clinical program notices and letters, and posters.
	◆ Ensuring the mailing of ID Cards and Plan education materials to Participants no later than December 15, 2014 for coverage effective January 1, 2015.
	◆ Detailing a plan to educate and enforce Plan benefits, utilization management, and other Plan specifics to all participating providers.
	◆ Participation in all activities related to a readiness assessment prior to the Effective Date (see AR-95).
	The development and execution of the Implementation Plan is subject to PG-1 of Attachment TR-10: Performance Guarantees and the liquidated damages of Section 6 of the Contract for failure to meet the milestones identified therein.
AR-2	The Service Provider shall be 100% operational prior to the effective date of January 1, 2015, 12:00:00 A.M. Service Provider is subject to the liquidated damages of Section 6 of the Contract for failure to meet this milestone.
AR-3	The Service Provider shall mail ID Cards (without Social Security Numbers) to all Participants the earlier of December 15, 2014 or ten business days after the receipt of a clean and accurate Open Enrollment eligibility file subject to PG-7(a).
II. Account Management	
AR-4	**<u>Account Manager</u>** a.) The Service Provider shall assign a dedicated and exclusive account manager as the primary contact for the Department.
	b.) The account manager shall participate on the implementation team.
	c.) If requested by the Department, the account manager shall be replaced with one that the Department is allowed to interview and approve.
AR-5	**<u>Account Management Team</u>** a.) The Service Provider shall assign a dedicated (but not necessarily exclusive) Account Management Team which shall include an executive sponsor, an account manager, a customer service manager, a data/fiscal analyst and a medical director.
	b.) The Service Provider agrees that the Customer Service Manager, as part of the Account Management Team, shall be dedicated and exclusive.
	c.) The Service Provider agrees that replacement of personnel to the Account Management Team assigned to this Contract shall be subject to the Department's prior written approval.
	d.) The Account Management Team shall act on behalf of the State to advance the best interests of the State through the Service Provider's corporate structure.

	e.) The Account Management Team shall devote the time and resources needed to successfully manage the State of Florida account, including being available for frequent telephonic, email, and on-site consultations.
	f.) The Account Management Team shall be thoroughly familiar with the Service Provider's functions and operations that relate directly or indirectly to the Department and the Plan, including, but not limited to, provider networks, customer service operations, claims and eligibility systems, systems reporting capabilities, claims adjudication policies and procedures, standard and non-standard banking arrangements, and relationships with third parties.
	g.) The Service Provider shall maintain a current Account Management Team organizational chart. The Service Provider shall promptly notify the Department of any change(s) to the organizational chart and/or the Account Management Team and provide detailed information regarding new personnel including name, professional background, mailing and physical address, email address, phone numbers and an updated organizational chart.
	h.) The Account Management Team shall be subject to two Performance Reviews developed and conducted by the Department each year. If any Performance Review score is less than the measurement criteria, an action plan must be implemented as mutually agreed to by the Department and the Service Provider. Performance will be measured using a Report Card and such review shall be subject to the standards and liquidated damages as described in PG-4.
AR-6	The Service Provider shall assign a dedicated (but not necessarily exclusive) eligibility manager for the Department.
AR-7	The Service Provider shall assign a dedicated (but not necessarily exclusive) billing manager for the Department.
AR-8	a.) The Service Provider shall assign a dedicated and exclusive claims supervisor for the Department.
	b.) The Service Provider shall assign dedicated and exclusive claims processors/adjustors for the Department.
	c.) The Service Provider shall assign a dedicated and exclusive claims facility for the Department.
AR-9	**Background Checks** Service Provider shall comply with the Employee and Subcontractor Security requirements, including the performance of background checks as described in section 3.3.5 of the Contract.

AR-10	Quarterly Meeting a.) Quarterly Meetings: The Account Management Team shall attend all quarterly meetings at the State offices in Tallahassee, Florida. The Service Provider shall not be entitled to additional compensation for meeting preparation or attendance. The meetings shall be held no later than 45 calendar days following end of the quarter. The meeting to review the fourth quarter of a calendar year shall include quarterly and annual reports and deliverables. This includes quarterly meetings, which may be held telephonically, throughout the 16-month period following the termination of the Contract resulting from this ITN. See PG-2.
	b.) Agenda: The Service Provider shall provide for Department approval a draft agenda five (5) business days in advance of a meeting, allowing changes to the agenda and a reasonable opportunity to prepare for the meeting. At a minimum, during the meeting the Service Provider and Department will: discuss medical goals, expectations and priorities; review the Service Provider's quarterly reports and other issues such as performance guarantees, quality assurance, operations, network status and access, benefit and program changes or enhancements, legislative issues, audits, cost trends, utilization, program outcomes, customer service issues, future goals and planning, and other issues reasonably related to the Contract. The Service Provider shall address past performance and anticipated future performance and compare the Plan's experience to national trends and the Service Provider's total book of business, other governmental clients, and the Service Provider's "best in class."
	c.) Minutes: Within five (5) business days after any meeting, the Service Provider shall provide the Department detailed and well-documented draft meeting minutes. The Department will review and revise the draft minutes as appropriate and return to the Service Provider. The Service Provider shall provide the Department with final minutes within three (3) business days after receipt of the revised minutes. Minutes shall include a list and description of all deliverables, identify the responsible party(ies) and provide projected delivery dates.
AR-11	Progress meetings, issue meetings and emergency meetings shall be held as needed. Either party may call such a meeting, subject to reasonable notice. Any meeting held in person shall be at the State offices in Tallahassee, Florida. The Service Provider shall not be entitled to additional compensation for meeting preparation or attendance.
III. Support Services	
AR-12	**<u>Benefit Fairs</u>** a.) The Service Provider shall participate in all locations of the annual Open Enrollment Benefit Fairs that are sponsored by the Department or its designee. (Twenty-four fairs were held in the fall 2012 Open Enrollment; however, the number and locations may vary each year.) The Service Provider representatives attending the Benefit Fairs shall be employees of the Service Provider (not subcontractors or temporary personnel) and adequately trained and knowledgeable about the Plan. Open Enrollment is held annually in the fall for

	enrollment coverage effective the following January 1. Participation is subject to PG-3.
	b.) The Service Provider shall be responsible for all costs associated with participating in Benefit Fairs including travel and a proportionate share of facility fees and the printing and distribution of the Benefits Document.
	c.) The Service Provider shall not solicit State Employees for enrollment or otherwise during the Employee's working hours or in the Employee's work place, except during meetings which may be scheduled by the Department.
AR-13	The Service Provider shall not discuss with Participants or prospective Participants or in any manner allude to coverages, products, or materials other than those contained in the Plan without the permission of the Department. Such prohibition shall also apply to the Service Provider's Plan specific website.
AR-14	**Advertisements and Marketing Materials** a.) The Service Provider shall submit copies of any and all Plan materials to the Department for customization and prior written approval, if such material is distributed to Participants for marketing the Plan. All materials shall be approved in writing by the Department prior to their use.
	b.) The Service Provider shall share in any expenses for the printing and mailing of State of Florida Open Enrollment materials distributed by the Department, the cost for which shall be shared among all benefit plan providers including medical and prescription drug plans offered by the Department.
AR-15	**Plan Materials** Subject to the Department's customization and prior written approval, Service Provider shall be responsible, at no additional cost, for the development (including, but not limited to, the writing, printing, distributing and mailing thereof) of all Plan-related printed materials including but not limited to: a.) Summary Plan Description (Plan Benefits Document) b.) Summaries of Material Modifications, as requested c.) Summaries of Benefits and Coverage (SBCs) d.) Member educational materials e.) Member Identification Cards f.) Benefit brochures (including, but not limited to, Open Enrollment materials) g.) Claim forms h.) Provider directories i.) Two Benefit Statements (one year-to-date and one in conjunction with Open Enrollment, to be received no later than the first day of Open Enrollment; and one distributed no later than February 15 of each year reflecting the full prior calendar year) for all members. Benefit Statements must show complete claim details, including plan and member cost share, deductible, out-of-pocket maximum, etc. for claims incurred during the applicable time period.

	j.) Explanation of Benefits Statements (EOBs) k.) Any other materials such as notices, preformatted letters, clinical program notices, other correspondence and similar material.
AR-16	The Service Provider shall assist the Department (i.e., review, clarify, edit as necessary and confirm accuracy) as requested in the development of Department communications regarding the Plan, including, but not limited to, the annual Benefits Guide and the Department's benefit website (www.myflorida.com/mybenefits).
AR-17	Upon request of the Participant, the Service Provider shall provide printed materials in a medium widely accepted for the visually impaired.
AR-18	All printed material shall be provided in electronic format with final versions submitted to the Department in PDF file format.
AR-19	Service Provider shall provide Plan materials in a culturally and linguistically appropriate manner, as defined by section 2719 of the Public Health Service Act (PHSA).
AR-20	**Provider Directory** a.) The Service Provider shall provide an online directory of network providers. The online directory available to members shall be updated and available in real time. The directory shall indicate that the list is subject to change.
	b.) The Service Provider shall mail provider directories to Plan Participants upon verbal or written request.
AR-21	**Membership Materials** The Service Provider shall provide the following materials to new Subscribers within seven (7) business days after receipt of the enrollment data file or notice from the Department or its designated agent: a.) Summary Plan Description (SPD), and b.) Identification Card(s) (ID Card).
AR-22	When the Service Provider mails the membership materials, they may include a customized greeting and form letter to new Participants. The greeting and letter are subject to Department customization and approval. This letter may include a summary of information already contained in the SPD or may highlight important Plan information.
AR-23	**Summary Plan Description (SPD)** The SPD shall include information on all covered services including, but not limited to, benefits, limitations, exclusions, copayments, coinsurance, policies and procedures for utilizing clinical and administrative services, procedures for registering complaints or filing appeals, and procedures for providing continuity of care when a provider's network status is terminated. The document shall be subject to the customization and approval of the Department.

AR-24	**ID Cards** a.) The Service Provider shall provide Participants with ID Cards either as a new Participant resulting from Open Enrollment, as an otherwise newly enrolled Participant, or when there are changes in the card's elements. The design of the ID card is subject to approval of the Department.
	b.) The Service Provider shall mail one (1) ID Card for each individual contract and at least one (1) additional ID Card for each family contract.
	c.) The Service Provider shall provide additional ID Cards as requested by the Participant.
	d.) The Service Provider shall make temporary ID cards available to Participants on its Plan specific Participant website that can be downloaded and printed.
	e.) A unique Participant-identifying number that is not a SSN shall be displayed on the ID Cards. Although never displayed, the SSN shall be the number of record and maintained in the Service Provider's information system. ID Cards shall be compliant with State of Florida standards, including section 627.642, Florida Statutes.
	f.) ID Cards, including those mailed in the fall of 2014 for the 2015 coverage year, annual Open Enrollment periods or otherwise as required due to Plan or law changes, shall be mailed in accordance to the provisions of PG-7.
AR-25	**Special Post-Office Boxes** The Service Provider shall maintain dedicated and exclusive post office boxes which shall be used for the Plan and Plan Participants.
AR-26	**Public Records Requests and Subpoenas** The Service Provider shall, upon request and at no additional cost, provide the Department with any necessary data, documents, etc. to enable the Department to timely respond to Public Record Requests and subpoenas related to any aspect of services delivered under the Contract.
AR-27	**Responding to Requests for Legislative Initiatives** The Service Provider shall make available all necessary resources (including, but not limited to, the Account Management Team, analytics and outcomes, research and development, actuarial support, and government relations departments) to assist the Department in responding to bill analysis, legislative inquiries and requests related to any aspect of services delivered under the Contract. The Service Provider shall respond within the timeframe set by the Department, which shall be determined at the time of the inquiry depending upon the scope and complexity of the request. All costing estimates/fiscal impacts shall be made on a PEPM (PEPM to include all Subscribers) basis unless otherwise requested by the Department. Support for such legislative initiatives shall be at no additional cost to the Department.

AR-28	The Service Provider shall review (and maintain) medical documentation and determine/confirm mental and/or physical disability status for Dependents of eligible Subscribers. The Service Provider must re-verify disability status every five years using a process approved by the Department.
AR-29	**Department Inquiries, Account Service and Dispute Support** The Service Provider shall, upon request of the Department or its attorneys and at no additional cost, assist the Department in responding to inquiries received by the Department from Participants, providers, or other persons related to any aspect of services delivered under the Contract. Such requests shall 1.) be given a priority status; 2.) be subject to a method of tracking; 3.) result in the delivery of all requested information, documentation, etc.; and 4.) be handled or overseen by a lead customer service person. When the Department is required to provide instant responses, the Service Provider shall immediately assist the Department in preparing its reply, including providing data and documentation within the timeframes prescribed by the Department at that time.
IV. Customer Service	
AR-29	a.) The Service Provider shall maintain a Customer Service Unit dedicated and exclusive to perform all aspects of Participant-related customer service and shall include a state-of-the-art call center. Calls to this unit shall be accepted and answered promptly by a live Customer Service Representative during the hours of 7:00 a.m. to 7:00 P.M. Eastern Time, Monday through Friday, excluding State holidays set forth in section 110.117, Florida Statutes.
	b.) The Service Provider shall maintain an exclusive Participant toll-free customer service number, which will permit access from anywhere in the United States. The Customer Service Unit is subject to PG-5 and PG-6.
AR-30	The Service Provider shall maintain a written service disruption plan or procedure to continue customer service activities when existing service is temporarily unavailable due to either scheduled or unforeseen events (e.g., relocating offices, repairing/restoring utility or power supply, upgrading phone systems, and other events). The Department shall be notified as soon as possible for scheduled disruptions and other events.
AR-31	**Plan Website** The Service Provider shall provide and maintain a Plan specific Participant website, with 24/7 access, for medical and general health information. Design and content shall be approved in advance by the Department. This website shall include links to the Department website, the PBM website and other state, federal, and medical condition specific/general health websites as appropriate to make available a variety of information to participants. Such web-based access shall include the ability to, at a minimum: a.) access forms and brochures; b.) order ID Cards; c.) download and print ID Cards;

	d.) access preventive educational information; e.) access general health and chronic disease information; f.) track accumulator information including separate tracking for both individual and family coverage (annual deductible and annual out-of-pocket coinsurance maximum); g.) locate network physicians and hours of operation; h.) locate network facilities and hours of operation; i.) view claim history (3 years minimum); and j.) communicate with a customer service representative.
AR-32	The Service Provider shall maintain a process for Participants, their authorized representative, or their provider to contact customer service to receive a written predetermination of benefits.
AR-33	**Subscriber Satisfaction Surveys** In addition to the annual Subscriber Satisfaction Survey required by AR-88(ab), the Department may conduct its own Member Satisfaction survey. The Department may conduct or have it conducted by an independent third party. If the survey results in unsatisfactory performance, the Service Provider shall implement a corrective action plan and/or changes to processes as approved by the Department.
AR-34	The Service Provider shall respond to and resolve all Participant inquiries (i.e. written, including email or member website, telephonic) within the timeframes specified in PG-9.
AR-35	The Service Provider agrees to adhere to leading industry practices in the development, implementation and application of administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the protected health information that the Service Provider creates, receives, maintains or transmits in the Service Provider's administration of the Plan, as required by the HIPAA security standards. Records shall be retained for ten (10) years after the later of (i) the final disposition of a claim, (ii) the expiration of this Contract, (iii) the conclusion of any judicial or administrative proceedings or audits or other action. Prior to the destruction of any such claim records, Service Provider shall consult with and obtain the prior written approval of the Department.
AR-36	All calls to the customer service unit shall be recorded in their entirety and easily retrieved throughout the entire term of the Contract.
V. Network Requirements	
AR-37	Service Provider shall provide and maintain a national comprehensive health care provider network of sufficient numbers and types of providers to provide adequate access to members. Network access shall be consistent with the minimum access standards identified by PG-10 to PG-13.
AR-38	The Service Provider shall notify the Department immediately if the Service Provider or provider network (owned, rented or leased) loses any accreditation,

	licenses or liability insurance coverage.
AR-39	If the Service Provider uses any rented or leased networks, the network(s) shall be transparent to the membership (e.g. single ID card, single provider directory, single point of contact for network inquiries, etc.).
AR-40	**Continuity of Care** a.) If a major provider's (facility, laboratory, imaging center or other large provider group) network status ends, the Service Provider shall notify impacted Participants 30 calendar days prior to the date of the network status change or as soon as administratively possible.
	b.) The Service Provider shall provide Continuity of Care as described on page 6-2 of the Benefits Document.
AR-41	The Service Provider shall provide the Department with at least 30 days prior notification and a statement of justification in the event of a major loss of network providers or disruption to the network (i.e. loss of a facility, large provider group, etc.). The statement shall include the following: a.) a description of how the contract action impacts the Plan participants; and b.) the facility or provider group's utilization by Plan members; and c.) a confirmation that the Service Provider shall continue to maintain minimum access standards, as described in PG-10 through PG-13. Service Provider shall keep the Department up-to-date on any contract negotiations/efforts to maintain the network status of the provider.
VI. Data Processing and Interface Requirements	
AR-42	**Eligibility File Transfers from the Department** The Service Provider shall maintain an information system capable of electronically receiving and updating Participant eligibility information. The Service Provider shall accurately convert and load the Department's eligibility files.
	a.) The Service Provider shall maintain eligibility records for all Participants based on the Department's eligibility file.
	b.) The Service Provider agrees that the Department's eligibility file shall be the official system of record. Service Provider shall not overwrite, update or in any way change the eligibility information without express direction from the Department or People First.
	c.) The Service Provider shall accept the eligibility files in a format required by the Department.
	d.) In addition to the file schedule above, the Service Provider shall accept an Open Enrollment eligibility file (generally provided at the end of November following Open Enrollment) for the purpose of generating ID cards for distribution prior to the coverage effective date.

	e.) The eligibility files, excluding the Open Enrollment eligibility file, shall be processed as required in PG-15.
	f.) Eligibility file transfers and subsequent discrepancy reports between the Service Provider and the Department shall be exchanged using a method required by the Department.
	g.) Eligibility updates (including manual reinstatements and terminations) from People First shall be processed as required in PG-15(b), at no additional cost to the Department.
AR-43	**Paid Claims File to the Department** The Service Provider shall provide to the Department and/or its authorized representative, on a monthly basis, a complete and detailed paid claim file, including all data deemed trade secret, proprietary or confidential (including, but not limited to, all claim related financial information: charged amount, allowed amount, discount; and provider information including location and National Provider Identifier or TIN), in a format specified by the Department. Failure to timely submit complete, properly formatted data shall be considered a material breach of the contract and shall be subject to PG-14(a).
AR-44	**Use of Plan Data** The Service Provider shall not sell or share the Plan's data without the prior written authorization of the Department.
AR-45	The Service Provider agrees that the only compensation to be received by or on behalf of its organization in connection with this Plan shall be that which is paid directly by the State.
AR-46	**System Upgrades, Enhancements and Problems** a.) The Service Provider shall provide at least six (6) months prior notice of any significant planned system upgrades or changes, including but not limited to claims, customer service, eligibility, operating systems and any other changes that may materially affect the administration of the Plan. Changes shall be subject to prior written approval by the Department. b.) The Service Provider shall immediately notify the Department upon the discovery of problems or issues impacting claims processing related to the Plan. Failure to timely notify the Department shall be considered a material breach of the Contract resulting from this ITN. c.) The Service Provider shall not take any corrective action related to systemic problems or issues impacting claims processing related to the Plan without the written approval of the Department.
AR-47	**Accumulator Exchange with PBM** On a daily basis (or more frequently as mutually agreed) the Service Provider shall: a.) Provide a file of all Participant accumulator information to the PBM and/or other required third-parties. This file shall be formatted as agreed upon by the parties and approved by the Department and is subject to PG-14(c). b.) Accept a file of all Member accumulator information from the PBM and other

	required third-parties. c.) Function as the "keeper" of the Member medical and drug spend accumulator information and update the applicable Member cost shares (i.e. remaining deductible, out-of-pocket maximum, etc.) using all pertinent information as appropriate and consistent with the Plan Designs.
AR-48	**Paid Claims Exchange with PBM** On a monthly basis (or more frequently as mutually agreed) the Service Provider shall:
	a.) Provide a file of all paid claim activity to the PBM and/or other required third-parties. This file shall be formatted as agreed upon by the parties and approved by the Department and is subject to PG-14(b).
	b.) Accept a paid claim file from the PBM and/or other required third-parties.
AR-49	**Health Insurance Management Information System (HIMIS)** The Service Provider shall provide all claim related data related to the Plan, including all data deemed trade secret, proprietary of confidential (including, but not limited to, all claim related financial information: charged amount, allowed amount, discount; and provider information including location and National Provider Identifier or TIN) to the Department and/or a third-party designated by the Department, in the timeframe and in the format specified by the Department. Failure to timely submit complete, properly formatted data shall be considered a material breach of the contract and shall be subject to PG-14(d).
AR-50	**Other Data Transfers as Required** File transfers between the Service Provider and the Department and/or authorized third parties shall be exchanged using a method, format and frequency required by the Department.
VII. Claims Processing	
AR-51	**Claims Processing and Adjudication** The Service Provider shall establish and perform all aspects of claims processing, coordination of benefits, claims reimbursement, point-of-sale transactions, claim adjudication and payment in accordance with the Benefits Document. The Service Provider shall verify benefits and eligibility before authorizing services.
AR-52	**Standard Claims Administration Practices** The Service Provider shall receive, process and adjudicate claims in accordance with best industry practices using nationally recognized standards.
AR-53	The Service Provider shall accommodate both a standard PPO plan and an HSA qualified High Deductible Health Plan design, as described in the Department's Plan Benefits Documents.
AR-54	The benefits to be provided are approved by the Florida Legislature and/or the General Appropriations Act. The Service Provider shall strictly adhere to the coverage provisions of the Plan Benefit Document, as amended and modified by law.

AR-55	The Service Provider agrees to make available a post-COBRA fully insured conversion policy to all terminated Participants.
AR-56	The Service Provider shall process claims in accordance with PG-16 through PG-19.
AR-57	The Service Provider shall prohibit network providers who render covered services to Plan Participants from billing such Participants for amounts in excess of the allowed amounts established by the Service Provider. Network providers may bill for applicable deductibles, copayments, coinsurance, per visit/administration fees, and non-covered services.
AR-58	The Service Provider shall determine order of liability for Coordination of Benefits as prescribed by applicable state and federal law, including Medicare.
AR-59	The Service Provider shall conduct other coverage liability (OCL) verification annually.
AR-60	**Coordination of Benefits** a.) As a secondary payer, the Service Provider shall reimburse as specified in the Coordination of Benefits section of the Benefits Document.
	b.) As a secondary payer, the Service Provider shall coordinate with Medicare and benefits shall be paid up to the lesser of 1) the covered expenses Medicare does not pay, up to the Medicare allowance; or 2) the amount this Plan would have paid if the Participant had no other coverage. Plan benefits for Participants who are eligible for Medicare Parts A and B but have not enrolled will be paid as if Medicare had paid first as the primary plan.
AR-61	**Coordination with Medicare's Third-Party Administrators** The Service Provider shall coordinate with Medicare's third-party administrators and shall ensure that claims are processed with primary and secondary payers without involving the Participant. The Service Provider shall be responsible for timely responding and resolution of all Medicare Secondary payer notices to avoid offsets to the State of Florida. Service Provider shall be financially responsible for its failure to accurately and timely resolve such MSP notices resulting in the offset of State funds.
AR-62	The Service Provider shall allow for and establish automatic crossover of claims directly from Medicare.
AR-63	**Explanation of Benefits Statement (EOB)** a.) The Service Provider shall furnish an Explanation of Benefits (EOB) to the Participant or Subscriber via regular U.S. Mail to the last known address following each processed claim. Such EOB design is subject to the customization and approval of the Department. The EOB shall include all specific claim details including accumulative balances, as applicable. A per-claim electronic EOB is allowed in lieu of a hard copy EOB, subject to the authorization of the Participant.

AR-64	**Accounting System** The Service Provider shall maintain an accounting system and employ accounting procedures and practices conforming to generally accepted accounting principles and standards. The Service Provider's accounting records and procedures shall be open to inspection by the Department or its authorized representatives at any time during the Contract period and for so long thereafter as the Service Provider is required to maintain such records; however, any such inspections shall be subject to confidentiality protocol requirements. All charges, costs, expenses, etc. applicable to the Contract shall be readily ascertainable from such records. Supporting documentation for all charges, fees, guaranteed savings and rebate payments shall be readily ascertainable from such records.
AR-65	**Appeal Services** a.) At no additional cost, the Service Provider shall administer appeals in accordance with the appeals process described in the Benefits Document and as otherwise specifically required by the Department. Such appeals include Level I appeals, medical review/assistance to the Department for Level II appeals/administrative hearings, and external reviews by the Service Provider's Independent Review Organization (IRO). Any and all correspondence, letters, communications, etc. related to any part of the appeals process is subject to the customization and approval of the Department. The Service Provider shall adhere to the standards prescribed in PG-21.
	b.) Appeal-related Documentation and Testimony: Upon request by the Department or its attorneys and within the timeframes specified by the Department, the Service Provider shall provide all documentation relative to a Plan Participant's appeal/administrative hearing(s). This documentation shall include, but not be limited to, clinical/medical policy guidelines, any notes, medical review notes or statements of medical providers and/or Service Provider's medical reviewers or consulting medical providers. Service Provider shall make available the documentation and testimony of the Service Provider's employees, physicians, nurses, consultants, associates and other personnel necessary for the Department's presentation of the review or appeal/administrative hearing(s), via telephone or in-person if required by the Department, at no additional cost to the Department.
AR-66	Pursuant to ss. 110.123(5)(g), Florida Statutes, the Service Provider shall provide written notice to Participants if any payment to any provider remains unpaid thirty (30) calendar days after receipt of the Claim.
AR-67	**Medical Necessity Determination and Review** a.) Prior to any denial of an appeal as not-medically-necessary, experimental and/or investigational, the appealed claim shall be reviewed by an appropriate medical professional. Service Provider shall apply the definition of "Medically Necessary," as set forth in the Benefits Document and in accordance with Service Provider's medical policy guidelines then in effect. The Service Provider shall create, maintain and annually update medical guidelines that are thoroughly researched using published medical literature. Except for eligibility appeals, the Department may

	request a medical review in any other instance.
	b.) In accordance with the Benefits Document and Florida Law, the Department shall have full and final decision making authority concerning eligibility, coverage, benefits, claims and interpretation of the Benefits Document.
AR-68	**Prescription Drug Rebates** Service Provider shall provide 100% of all prescription drug rebates collected and related to claims as part of this Plan. Such rebates are subject to quarterly report described in AR-77(q).
AR-69	**Fraud and Abuse Investigative Services** The Service Provider shall develop and/or maintain protocols, procedures, and/or system edits to aggressively monitor for fraud, abuse and waste, and shall provide the Department with a quarterly report of all fraud activities and discoveries relating to this Contract subject to the accuracy and timeliness provisions of PG-23 and PG-24. The protocols, procedures and/or system edits shall be provided to the Department upon request and are subject to the Department's customization and approval. The Service Provider shall investigate any fraudulent, suspected fraud or suspicious activity relating to the Plan, which it believes to be fraudulent or abusive whenever detected by the Service Provider or brought to the attention of the Service Provider by the Department or other persons. The Service Provider shall timely notify the Department of any fraudulent or abusive Claims or other activities relating to the Plan which it uncovers and shall fully cooperate with and assist the Department, law enforcement and State agencies in their investigations or inquiries regarding any such matters and in any related recovery efforts.
AR-70	**Subrogation** The Service Provider shall identify, to the extent possible, any claim payments for which the Plan has, or may have, a right of subrogation. The Service Provider shall make a reasonable and diligent effort to enforce, in accordance with Section 768.76, Florida Statutes and the Benefits Document, any possible subrogation claim belonging to the Plan. The Service Provider shall develop and implement a subrogation process subject to the approval of the Department. Service Provider shall pursue, settle and collect all subrogation rights allowed in the Benefits Document. If any settlement is recommended that is less than the State's full lien amount minus any cost sharing or reductions allowed by statute (s. 768.76 F.S.), the Department shall approve said settlement. Additionally, the Service Provider shall develop a monthly subrogation report, subject to the approval of the Department, for reporting the identification, status and resolution of all pertinent subrogation cases.

AR-71	**Inaccurate Payments** a.) Upon discovery, notification, or recoveries as part of audits (i.e. Service Provider self-audit, Department/Contract required audit, eligibility audit, provider audit) or other activities, the Service Provider shall fully rectify the inaccurate payment or other situation, including but not limited to collecting overpayments or mis-payments, whenever payment is made that is not in accordance with the terms of the Contract. The Service Provider shall recover any overpayments and refund 100% to the Department, when applicable. Such overpayments shall not be reduced by contingency fees or other fees charged by an auditor or other recovery service.
	b.) The Service Provider shall reimburse the Participant in the event that a recovery impacts the Participant's cost share.
AR-72	Service Provider shall provide copies of medical policy guidelines upon the request of the Department.
AR-73	**Online Reporting and Management Tools: Computer Access to Plan Data** a.) Service Provider shall provide for unlimited users from the Division, at no additional cost, online user access to its reporting and management services, systems, programs, current and historical OCL, customer service call and correspondence notes and logs.
	b.) Service Provider shall provide corresponding manuals and any other printed or digital material or CDs used in connection with the systems (related documents). This online tool shall have data accumulation, claims specific and ad-hoc reporting capability.
	c.) **Training:** Service Provider shall, upon request of the Department, provide designated Department staff with training at the Department's facilities for the online reporting and management tools. Additional training beyond the initial training following Contract implementation date may be requested from time to time as system updates occur, new Department staff is hired and need training, or other factors with all expenses to be paid by the Service Provider.
VIII. Reporting and Deliverables	
AR-74	The Service Provider shall acknowledge all report requests within one (1) business day and shall provide an expected completion and delivery date. Such reports may include, but are not limited to, Plan-specific financial and statistical data.
AR-75	The Service Provider shall provide all required reports and/or deliverables to the Department and/or its authorized third party in a format specified by the Department that provides utilization, claims reporting, and administrative services (i.e. administrative services only fees, or fees for optional clinical management programs) data both by plan (Standard or Health Investor), and by subgroup. The subgroups at a minimum are: Active, COBRA, Retirees Under 65, and Retirees 65 and Over. Note: The Department anticipates that the subgroups will ultimately include variable hour (hourly) employees.

AR-76	The Service Provider shall provide the required data and forecasts in support of the State Employee Group Program's Estimating Conference Report. Such data shall be provided in the timeframes and layout specified by the Department. Data may be required on both a PEPM (PEPM to include all Subscribers) and PMPM basis.
AR-77	The Department requires a number of regular weekly, monthly, quarterly, semi-annual and annual reports and/or deliverables. Reports shall be provided in a format subject to customization and approval of the Department. Reports shall contain all such data/details as required by the Department. Reports shall be delivered electronically to the Department and/or its designee, and in hard copy by request. Reports that contain proprietary, trade secret and/or confidential information shall also be delivered in a redacted format at the same time as the non-redacted format; the redacted report is only required to be delivered electronically. Complete and detailed backup/supporting documentation must be provided with the submission of each Report. Backup/supporting documentation must identify the source of the material. The Department may require Service Provider to propose and implement a reasonable Corrective Action Plan to address the root causes of any missed Performance Standard. Any such Corrective Action Plan is due within 30 calendar days of submission of a missed Performance Standard. Each weekly, monthly, quarterly, semi-annual and annual report and/or deliverable described below shall be subject to the accuracy and timeliness provisions of PG-23 and PG-24.
	Weekly Reports include:
	a.) **Eligibility Discrepancy Reports**
	i.) Duplicate records report ii.) Reject records report iii.) Address errors report
	Monthly Reports include:
	b.) **Paid Claims Report** A complete and detailed paid claims report/file as described in AR-43.
	c.) **Paid Claims Summary Report** A paid claims summary report both by plan (Standard or Health Investor), and by subgroup.
	d.) **Aged Claims Report** The Service Provider shall provide the Department with a report listing those claims that were not finalized within thirty (30) days and the status of any such claim.
	e.) **Claim Lag Report** The Service Provider shall provide the Department with a claim lag report.
	f.) **Overpaid Claims and Recoveries Report** The Service Provider shall provide the Department with a report of all overpaid claims, overpayment recoveries related to the Plan. Such report shall include information related to the overpaid/underpaid claim, including but not limited to, the individual claim number, date(s) of service, date(s) of recovery and date(s) of

	reimbursement.
	g.) **Subrogation Report** The Service Provider shall provide the Department with a Subrogation report as specified in AR-70, reporting the identification, status and resolution of all subrogation cases.
	h.) **Issued/Cashed Checks Report** The Service Provider shall provide the Department with a report of the issued/cashed claim payments related to the Plan.
	i.) **Special Claims/Surcharge Reimbursement Report** The Service Provider shall provide a detailed report for each category of surcharge/special claim reimbursements as specified in AR-97.
	j.) **Enrollment Demographics Report** The Service Provider shall provide the department with a report of the demographics of the enrolled population for the reporting month.
	j.) **Bank Reconciliation Report** The Service Provider shall provide a summary report reconciling daily claim activity to banking activity.
	Quarterly Reports include:
	k.) **Network Utilization Report** A paid claims report by in and out-of-network.
	l.) **Network Discount Guarantee Report** The Service Provider shall provide a report of their actual provider discounts compared to their guaranteed provider discounts related to the Contract resulting from this ITN.
	m.) **Performance Standards Guarantee Report** The Service Provider shall deliver the performance standards guarantee report. Upon delivery of this report, the Service Provider shall include detailed backup/supporting documentation for each performance standard (i.e. system generated call center stats/reports, etc.). Complete and detailed backup/supporting documentation must be provided with the submission of the Performance Standards Guarantee Report. Service Provider shall provide a detailed Corrective Action Plan that addresses each missed standard and that includes complete details of any proposed corrective action(s), the implementation date of such corrective action(s), the complement or validation date of such corrective action(s), and a schedule for monitoring to ensure future success of any implemented corrective action(s).
	n.) **Key Metric Cost and Utilization Report** The Service Provider shall provide comparative data on all key metrics, medical costs and utilization for Your book of business, public sector book of business, and best in class client(s).

	o.) **Utilization Report** The Service Provider shall provide a quarterly utilization report to the Department and/or its designee.
	p.) **Fraud, Abuse and Waste Report** The Service Provider shall provide a report with complete details of all instances of fraud, abuse and/or waste.
	q.) **Prescription Drug Rebate Report** The Service Provider shall provide a report with details of all prescription drug rebates collected and related to claims as part of this Plan.
	r.) **Clinician Staffed Toll-Free Service Line Report** The Service Provider shall provide a utilization report.
	s.) **Hospital Utilization and Cost Report** The Service Provider shall provide a utilization and cost hospital report for the top 25 in-network hospitals and top 25 out-of-network hospitals.
	t.) **Network Provider Add/Delete Report** The Service Provider shall provide a report of all additions and deletions from the network by city/state, county and specialty.
	u.) **Appeals Report** The Service Provider shall provide a report detailing the number of appeals received during the reporting period along with the nature and final determination of such appeals.
	v.) **Trend Analysis Report** The Service Provider shall provide a report explaining any unusual trend results (high/low) relative to the industry, Service Provider's book of business, public sector book of business, and best in class client(s).
	w.) **Clinical Program Reports** The Service Provider shall provide a report of the utilization, cost and savings associated with all participation in clinical programs, including, but not limited to: ◆ Case Management ◆ Disease Management ◆ Utilization Management
	x.) **Internal Audit Report** The Service Provider shall provide a report of internal audit results as described in AR-82.
	Annual Reports include:
	y.) **Renewal Report** The Service Provider shall provide a rate renewal report, which shall include at least the following information:

	◆ Projection of incurred claims costs for renewal year, a description of the methodology used to project incurred claims costs and justification of the use of any data not specific to the State of Florida; ◆ Detailed description of the methodology used to estimate claims trend; ◆ Estimate of IBNR at the end of current year, a detailed description of the methodology used to estimate IBNR, and up to the most recent 36 months of incurred/paid triangular claim reports for the State of Florida; ◆ Disclosure of supporting data used in calculations, including enrollment, large claims analyses, trend analyses, demographic analyses, etc.;
	◆ Credit to the State's experience equal to the sum of all revenues received from other entities (e.g. third party liability and subrogation recoveries, etc.) as a result of the State's utilization.
	z.) **Network Discount Guarantee Report** The Service Provider shall provide a report of their actual provider discounts compared to their guaranteed provider discounts related to the Contract resulting from this ITN based on claims incurred during the Plan Year. This annual report would not be subject to the timeliness standard in the Performance Guarantees and is due by April 15 following end of Plan Year.
	aa.) **Hospital Audit Report** Based on the results of the Service Provider's on-site audits as specified in AR-90, the Service Provider shall provide a report detailing the audit, its findings, and financial impact to the Plan and Participants.
	ab.) **Subscriber Satisfaction Survey conducted by the Service Provider** The Service Provider shall survey a statistically valid sample of Participants using Plan services to verify satisfaction levels relating to the Service Provider's customer service unit, claims processing unit, provider network and other related services and to gauge satisfaction with the Plan. The survey instrument is subject to the customization and approval of the Department. The results shall be reported in a format prescribed or otherwise approved in advance by the Department. Survey results are subject to the provisions of PG-8. Service Provider shall provide a detailed Corrective Action Plan that addresses each survey question where the responses were below the required standard and that includes details of the proposed corrective action(s), the implementation date of such corrective action(s), the complement or validation date of such corrective action(s), and a schedule for monitoring to ensure future success of any implemented corrective action(s). Timing of this report may be on a semi-annual basis.
	ac.) **Statement on Standards for Attestation Engagements 16 (SSAE 16) Report** The SSAE 16 Report shall be subject to the provisions of AR-86.
	ad.) **Performance Bond and Insurance Report** The Service Provider shall provide the Department with verification that sufficient coverage and a sufficient bond is valid and in effect for each calendar year as prescribed in Section 7 of the Contract.

	ae.) **Annual IBNR Report** The Service Provider shall provide the Department with an estimate of IBNR as of June 30 of each calendar year. The report shall include a detailed description of the methodology used to estimate IBNR and up to the most recent 36 months of incurred/paid triangular claim reports for the State of Florida.
	af.) **Annual Claims Target Guarantee Report** The Service Provider shall provide the Department with a report of actual paid claims incurred in each Plan Year in aggregate and on a PEPM basis (based on average actual enrollment for the Plan Year) in aggregate and for at least the following Subscriber types: active, pre-65 Medicare and COBRA. Please note that this report is not subject to the Performance Guarantee for timeliness of annual reports and shall be due 180 days after the end of each Plan Year.
IX. Clinical Services	
AR-78	If the Department chooses to carve-out and implement an Evidence Based Medicine or Disease Management program at any point during the Contract term the Service Provider shall cooperate fully with the Department's vendor, including coordination of care management activities or wellness initiatives and transmission of data to and from the vendor in a mutually acceptable format and at no additional cost.
AR-79	**Clinician Staffed Toll-Free Line** The Service Provider shall make available to all Plan Participants a 24/7/365 clinician staffed toll-free line. The clinical staff shall, at a minimum, address immediate/every day health issues/concerns and distribute educational materials.
AR-80	**Prenatal Education and Early Intervention Program** The Service Provider shall make available to pregnant Plan Participants a prenatal education and early intervention program to screen for potential risk factors and assist in the development of a personalized educational and monitoring program, including monitoring of high-risk pregnancies.
X. Audits	
AR-81	**Readiness Assessment** The Department and/or its authorized third party may conduct or have conducted a readiness assessment of specific claims or other areas of the Service Provider as determined by the Department prior to the Effective Date. Such assessment may include, but shall not be limited to, procedures, computer systems, claims files, customer service records, accounting records, internal audits, and quality control assessments.
AR-82	The Service Provider shall perform, no less frequently than quarterly, internal audits on a statistically valid sampling of claims and shall report results to the Department quarterly. Results shall be used to validate self-reported quarterly performance metrics for claim timeliness, processing accuracy, payment accuracy

	and financial accuracy.
AR-83	**Overpayment Recovery** The Service Provider shall reimburse the Department for any and all overpayments regardless of whether the overpayment is recovered from the Plan member or provider or how the error was discovered.
AR-84	**Compliance and Performance Audits** The State may conduct or have conducted performance and/or compliance audits, audits of specific claims or other areas of the Service Provider as determined by the Department. Reasonable notice shall be provided for audits conducted at the Service Provider's premises. Audits may include, but shall not be limited to, audits of standard operating procedures, computer systems, claims files, provider contracts, customer service records, accounting records, internal audits, and quality control assessments. The Service Provider shall work with any representative selected by the Department to conduct such audits. The Service Provider shall make an internal audit representative available to the State and/or the State's designee throughout the audit process.
AR-85	**Audit of Host Plans** The Service Provider shall provide 100% transparency and audit ability for any and all financial transactions related to claims incurred by Plan Participants in or out-of-network, in or out-of-state, and submitted by a provider, member or other third-party.
AR-86	**SSAE 16 External Audit** The Service Provider shall, at its expense, undergo an annual audit in accordance with the AICPA Statement of Auditing Standards, A.U. Section 324-Reports on the Processing of Transactions by Service Organizations, specifically reporting on the Policies and Procedures Placed in Operation and Tests of Operating Effectiveness. The report shall cover the 12-month time period of July 1 through June 30 of each year. Reports are due to the Department by October 1 each year following the 12-month time period of July 1 through June 30. The audit shall be performed by an independent accounting/auditing firm. The Service Provider is required to provide prior timely notice to the Department of the independent accounting/audit firm conducting the audit with the Department being permitted to review and comment on the audit period and the associated scope of the audit. The SSAE 16 Report shall be subject to the provisions of PG-26.
AR-87	**Audits** a.) The Service Provider shall provide the State of Florida, the Department and the Department's third party auditor at least the following audit access, in addition to any other audit rights specified in the ITN, the Technical Proposal, the Contract and the Financial Proposal: 1.) To audit any data necessary to ensure the Service Provider is complying with all contract terms; such audit rights include but not are not limited to: 100% of claims data, approved and denied utilization management reviews, clinical program outcomes, appeals, and information related to the reporting and measurement of

	performance guarantees; 2.) To audit post termination; 3.) To audit more than once per year if the audits are different in scope or for different services; 4.) To perform additional audits during the year of similar scope if requested as a follow-up to ensure significant or material errors found in an audit have been corrected and are not recurring, or if additional information becomes available to warrant further investigation; and 5.) To submit to an annual audit of contractual compliance.
	b.) The Service Provider shall cooperate with requests for information, which includes, but is not limited to, the timing of the audit, deliverables, data/information requests and the response time to questions during and after the process. The Service Provider shall also provide a response to all findings that the Service Provider receives within 15 days, or at a later date if mutually determined to be more reasonable based on the number and type of findings.
AR-88	**Audit Findings** a.) Upon the discovery of any overpayment(s) that result in financial harm to the Department, the Service Provider shall immediately (prior to any recovery effort) reimburse the Department 100% of the total overpayment amount upon finalization of the audit. Overpayments arising from audit findings are not to be offset from claims or administration experience and must be paid separately.
	b.) If an audit finding determines that there are systematic issues affecting the adjudication of claims related to the Plan, the Service Provider shall coordinate with the Department to develop and immediately implement a corrective action plan subject to the customization and approval of the Department.
AR-89	The Service Provider agrees to the additional audit provisions of Contract Section 4 Audit.
AR-90	**Hospital Audits** a.) The Service Provider agrees to perform hospital records audits (including clinical and billing issues) on each hospital admission exceeding $50,000 in paid claims. In the event that the number of claims exceeding $50,000 in paid claims represents less than 2% of all hospital admissions, the Service Provider shall perform additional hospital records audits on those claims less than $50,000 beginning with the highest paid amount and continuing in decreasing order until at least 2% of all hospital admissions have been audited.
	b.) The Service Provider agrees to report such audit results and recoveries to the State in accordance with PG-25.

AR-91	**Quality Assurance Reviews for the Auditors** On a regularly scheduled basis, the Service Provider shall review its procedures and processes to assess quality performance on claims, suspense, adjustments, as well as customer service inquiries by phone, mail, email, etc. At the time of the audit, the Service Provider shall advise the Department (including producing any policies and procedures) on how the following areas are handled to ensure quality:
	a.) Technical
	b.) Claim turnaround times
	c.) Financials
	d.) Call center and customer service
	e.) Mailroom operations
	f.) Imaging/record retention
	g.) Claims processing
	h.) Invoices/invoice generation
	i.) Write-offs
	j.) Recovery of overpayments
	k.) Paper claims payments and reimbursement
	l.) Any other activity related to the administration of Services under the Contract resulting from this ITN.
XI. Payment Specifications	
AR-92	The Service Provider shall accept payments from the State processed through the State's standard transmittal process (i.e. EFT transfer to the Service Provider) and by State determined due dates. The Service Provider must complete a direct deposit authorization form (currently form number DFS-A1-26E rev.12/2010).
AR-93	The Service Provider shall provide any payments to the State through the normal transmittal process (i.e. EFT transfer from the provider) and by State determined due dates.
AR-94	All payments to the State shall be made separately by electronic funds transfer from any payment balances due from the State. The netting of payments related to the Plan is prohibited.
AR-95	The Service Provider shall remit overpayments to the Department monthly by electronic funds transfer. Such overpayments shall reconcile with the monthly report required in AR-77.
AR-96	Service Provider shall conform to the following procedures for the invoicing of contracted fees.
	Invoicing for Contracted Fees

	a.) The Service Provider shall provide the Department an itemized invoice for administrative fees and charges no later than the 10th day of each month following the month services were rendered. Invoices shall be based on the last weekly eligibility file of the coverage month and shall separately include detail regarding any enrollment adjustments (i.e. to capture adds/deletes). Required detail and documentation for such invoices shall be as specified by the Department and shall provide sufficient detail for pre and post audit. Invoices and supporting documentation shall be provided electronically and, upon request, via paper hardcopy.
	b.) Upon determination by the Department that the invoices are satisfactory and that payment is due, the Department shall process each invoice in accordance with the provisions of section 215.422, Florida Statutes. The Department shall forward payment through electronic funds transfer to the Service Provider for the invoiced amount. If the Department contests the invoice charges as submitted, additional documentation may be requested.
	c.) **Establishment of Account for Payment of Claims** The Service Provider shall establish and maintain a medical claims reimbursement demand deposit bank account for use by the Service Provider in assigning, reporting and providing audit controls for Department claim liability for medical claims benefit payments made solely under the Contract resulting from this ITN.
	This account shall only be used by the Service Provider for:
	◆ Requesting funding
	◆ Providing online detailed reconciliation data, which shall be provided within 24 hours of liability assignment
	◆ Detailed monthly issued/cashed reporting on medical claim payments made to or on behalf of those Participants under the Plan
	◆ All benefit payments made related to the Plan shall be made by Service Provider on tamper resistant drafts or through secured electronic funds transfer (EFT) reimbursed through this bank account
	d.) The Service Provider shall cover day 1 claims liability prior to invoicing the Department on day 2. Service Provider shall provide daily invoice notices via email and/or facsimile to the Department covering all checks presented (cleared), excluding outstanding issued checks, and EFT payments settled for the prior day and the Department will wire payment to Service Provider's designated demand deposit bank account previously agreed upon by the Department.
	e.) The Service Provider shall provide a minimum of 90 days notice to the Department if Service Provider elects to change the bank account. Service Provider shall suspend issuance of drafts or electronic funds transfers in payment of medical claims upon receipt of written notice of termination of contract to the designated representative of the Service Provider by the Department.

	f.) The Department shall only reimburse Service Provider's daily invoices for EFT transactions and cleared checks that have been presented to Service Provider's bank account; issued and outstanding checks will not be included in the reimbursement.
	g.) **Daily Written Draft Register** The banking contract will include, but will not be limited to, a record of electronic funds transfers and/or the transmission of a daily written drafts register by the Service Provider to the bank for positive confirmation procedures. The transmission must include the draft number, draft amount, the payee's name and date of draft. The method of transmission shall be determined by mutual agreement between the Service Provider and the Department's bank with approval by the Service Provider's bank.
	h.) **Reconciliation Task** The Department shall identify the necessary documentation and the related reporting requirements for the reconciliation. The Service Provider shall submit to the Department recommended processes and internal controls developed by the Service Provider to identify payments due to overbilling and other errors that may occur as part of the payment process. Reconciliation activities shall include but are not limited to:
	◆ Daily notification of amount of request
	◆ Listing of daily charged claim activity report (claim charge activity by check/item and Participant)
	◆ Daily detail report for transfer evaluation (all claim charge items at the Subscriber level)
	◆ Monthly bank account statement
	◆ Monthly summary of daily bank activity for each calendar year
	◆ Monthly Outstanding Report #1 (checks less than 90 days old that have not cashed)
	◆ Monthly Outstanding Report #2 (checks that are more than 90 days old that have not been cashed)
	◆ Monthly aged outstanding report with stop payment placed (details in-house stop payments placed on items that remain uncashed 12 months from issuance)
	◆ Monthly issue/cashed reconciliation report (issued vs. cashed items in a policy month)
	i.) **Electronic Funds Transfer (EFT) for Claim Payees** Along with standard draft issuance, upon Department approval concerning security and any other related issues, the Service Provider may, once balanced and validated, submit Electronic File Transfer (EFT) files to the established bank Mailbox to be retrieved by the bank, which is separately contracted by the State, In the event of use of EFT payments, Service Provider shall reconcile and create an acceptable audit trail. The EFT Files shall continue to be created in ACH format by the Service Provider's Claims/Financial Systems.

	j.) **Draft Stock** Service Provider shall provide the stock of tamper resistant bank drafts to be used in making authorized payments.
	k.) **Change of Bank Accounts** Should the Department elect to change bank accounts, the Service Provider shall not charge the Department for the cost of the change or any unused draft bank stock.
	Fraud and Abuse Reimbursements
	l.) The Service Provider shall provide quarterly a detailed fraud and abuse report and shall reimburse the Department all recoveries from fraud investigations and audits. Service Provider shall report all such recoveries in a manner such that each recovery can be linked to a specific claim and Participant.
AR-97	**Special Claims Reimbursement** a.) The Service Provider shall process expenses incurred on behalf of Plan Participants receiving services out-of-state including but not limited to surcharges and assessments required by other states.
	b.) New York Health Care Reform Act - The Service Provider shall process the required surcharge expense for Claims submitted directly to the Service Provider and shall process the monthly assessment for all Plan Participants living in the State of New York.
	c.) Massachusetts Uncompensated Care Act - The Service Provider shall process the required surcharge on Claims for services from acute care hospitals and ambulatory service centers located in the Commonwealth of Massachusetts.
AR-98	The Service Provider agrees that, upon contract termination or expiration, the cost of any work required by a new administrator to bring records in unsatisfactory condition up to date shall be the obligation of the Service Provider and such expenses shall be reimbursed by the Service Provider within thirty (30) days of receipt of an invoice from the new administrator. The Department shall make final determination regarding the condition of data and the Service Provider's obligation under this provision.
XII. Post Termination	
AR-99	Following the termination of the Contract, the Service Provider shall ensure that the Services required by this ITN and subsequent Contract are maintained at the required level of proficiency.
AR-100	**Run-Out Claims** a.) The Service Provider shall be responsible for the administration of claims incurred through the Contract expiration date.

	b.) Service Provider shall continue to process and adjudicate run-out claims in accordance with the terms of this Contract, and perform any related necessary claim services (including medical review) and adjustments, customer service activities, Department and Auditor General audit and support services, banking activities, and any other mutually agreed upon activity(ies) through the end of 16-months following the effective date of termination of the Contract.
AR-101	Through the end of 16-months following the effective date of termination of the Contract, the Service Provider shall continue to provide the following:
	◆ Mailroom services
	◆ Appeals Services
	◆ System/technical services
	◆ Claim entry, adjudication and adjustments based on the Plan Benefits Document
	◆ Cost containment services
	◆ Coordination of Benefits
	◆ Subrogation tasks
	◆ Customer service and call center operations
	◆ Medical review as necessary
	◆ Issue payments/checks and Explanation of Benefits Statements
	◆ Collection of overpayments
	◆ Banking activities
	◆ Reports
	◆ The Department and Plan Participants shall continue to have the same current online system access to information
	◆ Other tasks as required by the Department
AR-102	All claim records, including all data elements of such electronic claim records, and eligibility data used by the Service Provider relating to this Contract shall remain the property of the State and shall be provided to the State immediately upon contract termination and at the end of the 16-month period following termination of the Contract.
AR-103	**Transition to Subsequent Service Provider** a.) Upon the earlier of six (6) months before the expiration of the Contract or upon any notice of termination of the Contract, Service Provider shall provide transition services to the Department.
	b.) Transition services shall be provided up to twelve (12) months unless otherwise waived by the Department.
	c.) Transition services shall include: ◆ Continued provision of all Services until a subsequent Service Provider is prepared to provide all essential Services ◆ Service Provider's cooperation with the Department, its consultant or designee and the succeeding vendor designated by the Department ◆ Notification and description of current procedures

	◆ Listing of equipment and software licenses in use to provide the Services ◆ Explanation of operations ◆ Submission of a schedule for timely transition activities ◆ Return of all Department-owned materials ◆ Respond to all inquiries on an as-needed basis
	d.) For the services identified in item (c.) above, the services shall (i) be provided at no additional cost if the Contract expires or is terminated by the Department for cause, terminated by the Department for convenience or by Service Provider for cause.
	e.) In addition to the services specified in this requirement, upon termination of the Contract resulting from this ITN, the Service Provider shall transfer all data related to the Plan that is requested by the Department and/or the subsequent Service Provider, in a format approved by the requestor, at no additional cost. Data requested shall be provided within ten (10) business days.
XIII. Special Provisions	
AR-104	Unless otherwise agreed in writing, (i) Service Provider and its subcontractors and agents will not perform any of the Services outside of the United States, and (ii) Service Provider will not allow any of the State of Florida data to be sent, transmitted, viewed or accessed outside of the United States; consistent with Section 3.3.6 of the Contract.
AR-105	The Service Provider must own at least 80% of their proposed network within the State of Florida. Any processes, services, deliverables, etc., that are subcontracted or provided by a subsidiary or third-party (including but not limited to the provider network, clinical management, customer service, disease management vendors, printing services, etc.) shall be managed through the Service Provider and be seamless and transparent to both the members and the Department.
AR-106	The Service Provider shall notify the Department immediately if the Service Provider loses any accreditation, licenses or liability insurance coverage.
AR-107	The Service Provider shall provide annual certification of bonds and insurance coverages, consistent with Section 7 of the Contract.
AR-108	The Service Provider shall provide necessary legal defense and assistance as required in the event of litigation for services related to the performance of the Contract.
AR-109	The Service Provider shall cover all costs associated with legal defense in the event of any Plan-related litigation.
AR-110	The Service Provider shall absorb all costs associated with any benefit design changes.

AR-111	The Service Provider agrees that responses to this ITN are based on the specified benefit design, and that deviations regarding copayments, coinsurance, enhanced benefits, etc., shall not be included and will not be considered in phase one of the ITN. However, discount programs offered to all of the Service Provider's commercial clients may be included if the Service Provider's ITN response offers it at no additional cost.

Third Party Administrator Services
EXHIBIT B: Performance Guarantees

It is critical to the success of the State's benefits plans that services be maintained in a timely manner and that the Service Provider operates in an extremely reliable manner. It would be impracticable and extremely difficult to repair the actual damage sustained by the State in the event of certain delays or failures in claims administration, service, reporting, and attendance of Service Provider personnel on scheduled work and provision of services to the State Employees, Retirees and Dependents served by this Contract. The Department and the Service Provider, therefore, agree that in the event of certain such delays and failures, the amount of damage that will be sustained will be the amounts set forth in this Exhibit. Further, the Service Provider agrees that in the event of any such failure of performance, the Service Provider shall pay such amount as liquidated damages and not as a penalty. At its option, the Department may, for any amount due to the State as liquidated damages, deduct such amount from any money payable to the Service Provider or may bill the Service Provider as a separate item.

All references to "ARs" are to the Administrative Requirements of Exhibit A.

Performance Indicator		Standard/Goal	Measurement Criteria	Measurement Frequency	Amount of Risk
I. ACCOUNT MANGEMENT					
PG-1	Final Implementation Plan	a.) The Service Provider shall provide the final Implementation Plan, inclusive of all the details described in AR-1 through AR-3 to the Department no later than the date specified.	Delivery no later than ten (10) business days following contract execution	One time measurement	$1,000 per day for each calendar day past the due date that the final Implementation Plan, inclusive of all details, is not received by the Department

PG-2	Quarterly Meetings	The Account Management Team will attend and participate in all required quarterly performance meetings as described in AR-11.	100% attendance as required	Quarterly	$2,000 per meeting in which each member of the Account Management Team is not in attendance unless pre-approved by the Department
PG-3	Open Enrollment Benefit Fairs	The Service Provider shall guarantee Service Provider employees at each annual open enrollment meeting and/or benefit fair sponsored by the Department or its designee as described in AR-12.	100% of benefit fairs will be staffed as required	Annually	$20,000 per benefit fair not staffed as required
PG-4	Account Management Survey/Report Card	Performance of the Account Management Team shall be based on semi-annual Report Cards developed and evaluated by the Department as described in AR-5(h).	Score of at least 4.0 on average on a scale of 1 to 5	Semi-annually	$50,000 for each Report Card with an average score of less than 4.0
II. CALL CENTER PERFORMANCE					
PG-5	Service Level/Average Speed to Answer	a.) Inbound customer calls received by the dedicated Customer Service Unit described in AR-29 shall be answered by a live agent within the specified target time threshold. The target time threshold is measured from the time that the call is presented in the call queue for an agent and does not include any time when the caller was navigating the automated system prior to entering	90% of all calls shall be answered within 20 seconds or less	Quarterly	$2,000 per percentage point, or fraction thereof, less than 90.0%

		the call queue, if applicable.			
		b.) The average wait time for all inbound customer calls received by the dedicated Customer Service Unit described in AR-29 that are presented to the call center agent queue shall be answered within the specified time target. The target time threshold is measured for all calls presented in the call queue for an agent, including calls answered by a live agent and calls that are abandoned while in queue.	Average wait time for all calls presented in queue shall be within 30 seconds or less.	Quarterly	$2,000 per second above the target
PG-6	Call Abandonment Rate	The percentage of calls received that are terminated by a Participant before a live person answers shall not exceed the specified rate.	Less than or equal to 2.0%	Quarterly	$2,000 per percentage point, or fraction thereof, greater than 2.0%
PG-7	ID Cards	a.) Open Enrollment: ID cards shall be mailed to Subscribers no later than December 15, following receipt of the Open Enrollment file as described in AR-24.	99.9% or more will be mailed no later than December 15	Annually	$2,000 per percentage point, or fraction thereof, less than 99.9%
		b.) Maintenance: ID cards throughout the calendar year shall be mailed within the time specified following receipt of a processable eligibility file as described in AR-24.	99.9% or more will be mailed within four (4) business days of receipt	Quarterly	$10,000 per percentage point, or fraction thereof, less than 99.9%

PG-8	Subscriber Satisfaction Survey	Measured as the percentage of respondents conveying a satisfaction level in response to a Department approved Subscriber Satisfaction Survey as described in AR-77(ab).	a.) Initial Contract Year: The level of overall satisfaction will be greater than or equal to 90.0%	One time measurement	$100,000 when the overall satisfaction is less than 90.0%
			b.) Subsequent Contract Years: The level of overall satisfaction will be greater than or equal to 95.0%	Annually	$100,000 when the overall satisfaction is less than 95.0%
PG-9	Participant Inquiry Response Time	a.) Percent of telephone inquiries returned by a customer service representative.	99.0% within two (2) business days	Quarterly	$2,000 for each full percentage point below 99.0%
		b.) Percent of written inquiries responded to by a customer service representative	99.0% within ten (10) business days	Quarterly	$2,000 for each full percentage point below 99.0%
III. NETWORK ACCESS					
PG-10	Access Rate to Primary Care Physicians	The Service Provider shall establish and maintain a network of participating physicians to provide services under the plan.	a.) For urban and suburban areas, 98% of Subscribers will have at least two (2) providers within 10 miles of their home ZIP Code	Annually	$5,000 for each full percentage point below 98%

			b.) For rural areas, 98% of Subscribers will have at least one (1) provider within 15 miles of their home ZIP Code	Annually	$5,000 for each full percentage point below 98%
PG-11	Access Rate to Pediatricians	The Service Provider shall establish and maintain a network of participating physicians to provide services under the plan.	a.) For urban and suburban areas, 98% of Subscribers will have at least two (2) providers within 10 miles of their home ZIP Code	Annually	$5,000 for each full percentage point below 98%
			b.) For rural areas, 98% of Subscribers will have at least one (1) provider within 30 miles of their home ZIP Code	Annually	$5,000 for each full percentage point below 98%
PG-12	Access Rate to Specialists and OB/GYNs	The Service Provider shall establish and maintain a network of participating physicians to provide services under the plan.	a.) For urban and suburban areas, 98% of Subscribers will have at least two (2) providers	Annually	$5,000 for each full percentage point below 98%

			within 10 miles of their home ZIP Code		
			b.) For rural areas, 98% of Subscribers will have at least one (1) provider within 30 miles of their home ZIP Code	Annually	$5,000 for each full percentage point below 98%
PG-13	Access Rate to Hospitals	The Service Provider shall establish and maintain a network of participating hospitals to provide services under the plan.	a.) For urban and suburban areas, 98% of Subscribers will have at least one (1) hospital within 10 miles of their home ZIP Code	Annually	$5,000 for each full percentage point below 98%
			b.) For rural areas, 98% of Subscribers will have at least one (1) hospital within 20 miles of their home ZIP Code	Annually	$5,000 for each full percentage point below 98%
IV. DATA PROCESSING					

PG-14	Plan Data	a.) The Service Provider shall submit a complete file of all paid claims activity to the Department and/or its authorized representative, as described in AR-43, in the timeframe and format specified by the Department.	100% of medical paid claims activity shall be delivered no later than the 20th calendar day following the reporting month	Monthly	$2,000 per day for each business day that any such data is not provided as required
		b.) The Service Provider shall submit a complete file of all medical paid claims activity to the Department's PBM, as described in AR-48 within the time period specified.	100% of medical paid claims activity shall be delivered no later than the 15th calendar day following the reporting month	Monthly	$500 per day for each business day that the data is not provided
		c.) The Service Provider shall submit a complete file of all claim accumulators to the Department's PBM, as described in AR-47 within the time period specified.	100% of medical accumulators shall be delivered within 24 hours.	Monthly	$500 per day for each calendar day that the data is not provided
		d.) In support of a health management information system, the Service Provider shall provide all requested data related to the plan, as described in AR-49 in the timeframe and format specified by the Department.	100% of requested data shall be delivered no later than the 15th calendar day following the reporting month	Monthly	$2,000 per day for each business day that any such data is not provided as required

PG-15	Eligibility	a.) Routine Updates Eligibility files (as described in AR-42) shall be accurately and timely loaded within the time specified.	100% within two (2) business days of receipt	Quarterly	$2,000 for each day over the deadline, per incident
		b.) Non-routine Updates Ad hoc or non-routine manual enrollment updates at the request of the Department or its designee shall be completed in the time frame specified.	100% within the same business day if requested during normal business hours; otherwise, during the next business day	Quarterly	$2,000 for each day over the deadline, per incident
		c.) Eligibility Discrepancies Eligibility discrepancies (as described in AR-77(a)) shall be reported by the Service Provider to the Department and eligibility vendor in the time frame specified.	100% within two (2) business days of receipt	Monthly	$2,000 for each day over the deadline, per incident
V. CLAIMS PROCESSING					
PG-16	Claims Timeliness	Measured from the date the claim is received in the office (Day 1) to the date the processed claim reaches final action determination (including weekends and holidays) as described in AR-56. For electronically submitted claims, Day 1 is the date the claim was received, irrespective of time of day and including weekends and holidays.	a.) The average quarterly claims payment turnaround time will not exceed 14 calendar days for 90% of all non-investigated (clean) claims	Quarterly	$2,000 for each full percentage point below 90%

		For Paper claims, Day 1 is the date the claim was stamped upon receipt. The measurement methodology shall be: <u>Non-investigated (clean claims)</u> (Total number of original (clean) claims processed within 14 days / Total number of original (clean) claims processed during the quarter) <u>All Claims</u> (Total number of original claims processed within 30 days / Total number of original claims processed during the quarter)	b.) 100% of all claims will be paid within 30 calendar days	Quarterly	$2,000 for each full percentage point below 100%
PG-17	Financial Accuracy	Measured as the absolute value of financial errors divided by the total paid value of audited dollars paid based on quarterly internal audit of statistically valid sample. The measurement methodology shall be: (Amount of claims dollars in sample paid correctly / amount of claims dollars paid in sample) x (strata population dollars / total population dollars)	Average quarterly financial accuracy of 99.5% or more	Quarterly	$10,000 for each full percentage point below 99%

PG-18	Processing Accuracy	Measured as the percent of claims processed without non-financial error. The measurement methodology shall be: (Number of claims in strata sample without an administrative error / number of claims in sample) x (number of claims in strata population / number of claims in total population)	Average quarterly processing accuracy of 97% or more	Quarterly	$10,000 for each full percentage point below 95%
PG-19	Payment Accuracy	Measured as the percent of claims processed without financial payment error. The measurement methodology shall be: (Number of claims in sample paid accurately / number of claims in sample) x (number of claims in strata population / number of claims in total population)	Average quarterly financial accuracy of 98% or more	Quarterly	$10,000 for each full percentage point below 98%
PG-20	Overpayment Recovery	Measured as the amount of overpayments identified (by monthly Overpaid Claims Report) and recovered within 90 days, as described in AR-71.	90% of all overpayments identified shall be recovered and returned to the Department within 90 days.	Quarterly	$2,000 for each full percentage point below 90.0%

PG-21	Appeals	a.) The Service Provider shall finalize Level I Appeals (as described in AR-65) within the specified time frame.	100% of Level I Appeal determinations will be completed within: ◆ 15 days/pre-service ◆ 30 days/post service ◆ 72 hours/urgent	Quarterly	$10,000 for each full percentage point below 100%
		b.) The Service Provider shall provide information, support, documentation and/or testimony to the Department as requested for Level II Appeals and administrative hearings (as described in AR-65) within the time frame specified.	100% of requested information, support, documentation, and/or testimony will be provided to the Department by the date assigned by the Department.	Quarterly	$10,000 for each full percentage point below 100%

		c.) The Service Provider's external independent review organization (as described in AR-65) shall conduct such reviews within the time frame specified.	100% of IRO reviews will be completed within: ◆ 15 days/pre-service ◆ 30 days/post service ◆ 72 hours/urgent	Quarterly	$10,000 for each full percentage point below 100%
PG-22	Network Discount Guarantee	Service Provider's average discounts are guaranteed (including partner networks and/or rental networks, if applicable). Measured as the variance between actual annual discount (reflected in the annual Network Discount Guarantee Report) and Total Network Discount in **Exhibit E**.		Annually	$100,000 for each full percentage point that Total Network Discount exceeds actual annual discount
VI. REPORTING AND DELIVERABLES					
PG-23	Timeliness of the Delivery of Reports and Deliverables	Reports and deliverables shall be delivered to the Department and/or the Department's designee within the time period specified. **The Proposed Amount at Risk applies to each report outlined in AR-77 (except b and c)**.**	a.) Due weekly: Within 2 calendar days of end of the reporting week	Monthly	$500 per day for each calendar day past the due date that a report or deliverable is not received
			b.) Due monthly: Within 20 calendar days of end of the reporting month	Monthly	$500 per day for each calendar day past the due date that a report or deliverable is not received

			c.) Due quarterly: Within 45 calendar days of end of the reporting quarter	Quarterly	$500 per day for each calendar day past the due date that a report or deliverable is not received
			d.) Due annually: Within 45 calendar days of the end of the reporting year	Annually	$500 per day for each calendar day past the due date that a report or deliverable is not received
PG-24	Accuracy of Reports and Deliverables	Reports and deliverables that are delivered to the Department shall be accurate. (This Performance Guarantee does not apply to de minimus errors and omissions, as determined by the Department.) **Please note that the Proposed Amount at Risk applies to each report outlined in AR-77 (except b and c).**	a.) 100% of weekly reports or deliverables shall be mathematically and otherwise accurate	Monthly	$2,000 per report or deliverable
			b.) 100% of monthly reports or deliverables shall be mathematically and otherwise accurate	Monthly	$2,000 per report or deliverable
			c.) 100% of quarterly reports or deliverables shall be mathematically and otherwise	Quarterly	$2,000 per report or deliverable

			accurate		
			d.) 100% of annual reports and deliverables shall be mathematically and otherwise accurate	Annually	$2,000 per report or deliverable
VII. AUDITS					
PG-25	Hospital Audits	The Service Provider shall report audit results (as described in AR-90) and deliver and recoveries to the Department within the time frame specified.	a.) Report results within five (5) business days of audit completion	Quarterly	$500 per day for each business day that the report is not provided
			b.) Delivery of 100% of recoveries within 45 business days of audit completion	Quarterly	$500 per day for each business day that the recoveries are not delivered to the Department.
PG-26	SSAE 16 Report	The Service Provider shall provide SSAE 16 reports (as described in AR-86) within the time frame specified.	Report results by October 1 of each year	Annually	$1,000 per day for each business day that the report is not received

Third Party Administrator Services

EXHIBIT C: Plan Benefits Document

The State of Florida Plan Benefits document is subject to change by the Legislature. Service Provider is not entitled to any contract adjustment because of such changes.

Third Party Administrative Services Contract
Exhibit D: Approved Subcontractors

The following subcontractors have been approved by the Department. Any future additions or changes must be approved by the Department as provided in the Contract.

1. Alicare Medical Management, Inc.
   8C Industrial Way
   Salem, New Hampshire 03079
   (603) 328-6605

2. Audax Health Solutions, Inc.
   3000 K Street NW
   Suite 350
   Washington, DC 20007

3. Availity, LLC
   10752 Deerwood Park Blvd South
   Suite 110
   Jacksonville, FL 32256

4. CareCentrix, Inc
   7725 Woodland Center Blvd
   Suite 150
   Tampa, FL 33614
   (877) 561-9910

5. Customer Insights Research, Inc.
   517 N. Cortina St.
   Dewey, Arizona 86327
   (928) 239-4025

6. HealthDataInsights, Inc.
   7501 Trinity Peak Street
   Las Vegas, Nevada 89128

7. Health Dialog Services Corporation
   60 State Street, Suite 1000
   Boston, MA 02109

8. ICORE Healthcare, LLC
   6870 Shadowridge Drive, Suite 111
   Orlando, FL 32812

9. Iron Mountain
   745 Atlantic Avenue
   Boston, MA 02111

10. Johnson & Johnson – Centocor
    Centocor Ortho Biotech Services, LLC
    850 Ridgeview Drive, M.S. H-1-2
    Horsham, PA 19044

11. MCMC, LLC.
    300 Crown Colony Drive
    Suite 203
    Quincy, MA 02129

12. MES Solutions (Lone Star Consulting Services) (MES)
    100 Morse St.
    Norwood, MA 02062

13. Medical Review Institute of America (MRIOA)
    2875 S. Decker Lake Dr.
    Suite 300
    Salt Lake City, UT 84119

14. New Directions Behavioral Health, LLC
    4800 Deerwood Campus Parkway, Bldg. 600
    Jacksonville, FL 32246

15. National Imaging Associates (NIA)
    6950 Columbia Gateway Drive
    Columbia, MD 21046

16. OptumInsight
    1021 Windcross Ct.
    Franklin, TN 37067

17. Prime Therapeutics, LLC
    1305 Corporate Center Drive
    Eagan, MN 55121

18. WebMD Health Services Group, Inc.
    2701 NW Vaughn St., Suite 700
    Portland, OR 97210

19. Xerox Commercial Solutions, LLC
    2828 North Haskell Avenue
    Dallas, TX 75204

20. Summitt Health, Inc.
    2775 Haggerty Road
    Novi, MI 48377

21. Health Designs, Inc.
    35 Executive Way, Suite 110
    Ponte Vedre Beach, FL 32082

Third Party Administrator Services

EXHIBIT E: Fees and Claims

Claims and Administration

I. Administrative Fees

Service Provider's administrative fees, on a Per Subscriber Per Month (PEPM) basis, which is guaranteed for the Contract term, are as follows:

	2015	2016	2017	2018
Total ASO (PEPM)	**$17.50**	**$17.50**	**$17.50**	**$17.50**
Run-out ASO (PEPM)				**$17.50**

	2019	2020	2021	2022
Renewal ASO (PEPM)	**$18.00**	**$18.50**	**$19.00**	**$19.50**

II. Projected and Target Claims Cost

Service Provider's Projected and Target Claims Cost is based on the following Subscriber types: (i) Active Employees, (ii) Early Retirees, (iii) Medicare eligible Retirees, and (iv) COBRA. The Projected and Target Claims Cost includes in-network and out-of-network claims, and excludes prescription drugs (except for those drugs included in medical claims).

For each Plan Year after 2015, the Projected and Target Claims Cost will be based on the actual total paid claims incurred in the prior Plan Year for all Participants by Subscriber type plus the Paid Claims Expected Trend. For 2015, the Projected and Target Claims Cost is:

	2015
i. Active	$564,473,783
ii. Pre-Medicare	$46,744,041
iii. Medicare	$84,839,457
iv. COBRA	$7,926,108
Total Aggregate Projected and Target Claims	**$703,983,389**

Projected and Target Claims Costs (aggregate dollars) = Active + Pre-Medicare + Medicare + COBRA.

III. Allowable Adjustment Factors

Allowable Adjustment Factors will be used to develop mutually agreed upon annual adjustments to the Paid Claims Expected Trend for each subsequent Plan Year based on changes in enrollment, demographics and plan changes which may impact total paid claims.

IV. Paid Claims Expected Trend

The amount of trend used to determine the claims target will be based, in part, on the trend letter provided by the Service Provider to the Department for the Estimating Conference held in either January or February of the respective Plan Year. The trend letter will be based on claims paid in the previous Plan Year. The Parties will use the Allowable Adjustment Factors and the trend letter to develop a mutually agreed upon "Paid Claims Expected Trend."

V. Claims Target Guarantee

No later than March 31 of the respective Plan Year, the Service Provider shall provide a Claims Target Guarantee for the respective Plan Year (using the Projected and Target Claims Cost and mutually agreed upon Paid Claims Expected Trend) on a total aggregate basis. Medicare Subscribers shall not be included in the Claims Target Guarantee. The Claims Target Guarantee will establish a risk corridor of 105% of the guarantee for the eligible populations.

Individuals with annual claim amounts in excess of $750,000 shall have the claim amount above $750,000 excluded from the calculation of the 105% corridor. Beginning in Year 2 of the Contract, the $750,000 amount shall be indexed to the Paid Claims Expected Trend for that Plan Year. The Department will be responsible to pay medical claims up to the 105% corridor. The Service Provider shall be responsible for 100% of actual paid claims above the 105% corridor, capped at 20% of the total administrative fee(s) for the Plan Year.

The Claims Target Guarantee will be assessed annually based on the receipt of the Annual Claims Target Guarantee Report specified in the AR-77(af). The PEPM basis guarantee amount will be calculated by dividing the aggregate Claims Target Guarantee by the average actual enrollment for the preceding Plan Year. The Department will compute (excluding Medicare as noted above) the actual paid claims and divide by the average actual enrollment for the preceding Plan Year to establish the "Realized PEPM Claims." The risk corridor established by the Claims Target Guarantee will be compared to the Realized PEPM Claims. If the Realized PEPM Claims exceed 105% of the Claims Target Guarantee, the Service Provider shall remit the appropriate amount to the Department no more than 15 Calendar Days after the receipt of the annual report.

Service Provider Calculations

- *Claims Target Guarantee = Projected and Target Claims Cost (Active + Early Retiree + COBRA Only) + Paid Claims Expected Trend (Delivered in January or February)*
- *Risk Corridor = Claims Target Guarantee * 1.05 (Delivered to DSGI by March 31 of Plan Year)*
- *Risk Corridor (PEPM) = Risk Corridor / Actual Average Enrollment (Subscribers) (Computed after end of Plan Year)*

DSGI Calculations

- *"Realized PEPM Claims" = (Actual Spend for Plan Year – Claims amounts over $750,000) / Actual Average Enrollment (Subscribers) (computed after end of Plan Year)*
- *If "Realized PEPM Claims" > Risk Corridor (PEPM); Multiply the amount in excess of the risk corridor (PEPM) by Average Actual Enrollment and Service Provider is responsible to remit entire amount above the risk corridor to Department, limited to a maximum of 20% of the Administrative Fees paid in the respective Plan Year.*

VI. Network Discounts

Service Provider guarantees that its Aggregate PPO Network Discount will be no less than **62 percent.** The following exclusions shall apply:

1) COB Excluded, including Medicare COB
2) Duplicate Claims Removed
3) Claims Where Billed Equals Allowed

Third Party Administrator Services

Exhibit F: Clinical Management Programs

The following Clinical Management Programs will be provided by the Service Providers at no cost to the Department and Participants.

I. Included Clinical Management Programs (at no additional cost)

Program	Description
PreService/Prior Authorization Program	**Brief Description:** Authorization prior to a service being rendered is required for inpatient hospitalization, outpatient surgery, durable medical equipment (DME), home healthcare, physical therapy, rehabilitation centers, skilled nursing facilities (SNF), Behavioral Health, high dollar radiology procedures, certain specialty drugs, and Hospice, as applicable, unless otherwise exempt by legislation. Specific procedures and services have been identified which require submission of a written request for prior approval (e.g., transplants). In addition to the written request, The practitioner must submit documentation supporting the need for the requested procedure and/or service. **Impact:** 100% of applicable participants. The purpose of the authorization process is to review and determine benefit coverage for payment of services/procedures being requested, in order to manage medical costs and to improve the delivery and quality of medical care. **Administrative Requirements:** As the incumbent carrier, this program is currently in place and will continue as currently administered.

Concurrent Review Program	**Brief Description:** Nurses conduct onsite or telephonic concurrent care review for participants admitted to acute and non-acute facilities in order to determine the appropriateness/effectiveness of services during a participant's stay while at that facility. Review is conducted in a consistent manner through the use of appropriate, clinically based criteria and determinations are made for continued coverage or non-coverage of the services being rendered. **Impact:** 100% of applicable participants. Concurrent care reviews also serve to facilitate a timely discharge, to identify any follow-up care needs and/or case management referrals, and to identify any potential quality of care issues. **Administrative Requirements:** As the incumbent carrier, this program is currently in place and will continue as currently administered.
Post Service Review Program	**Brief Description:** Post-service review activity (e.g., the initial review of a service already received by the participant) is carried out by nurses utilizing appropriate clinical criteria for authorizing payment of the service/procedure received. If criteria are not met, the potential adverse benefit determination is presented to a Care Management Medical Director with supporting information for additional review and discussion. If the Care Management Medical Director makes an adverse benefit determination to deny coverage for payment, the requesting practitioner, and the participant is notified of the adverse benefit determination and the participant is advised of his/her appeal rights. If a pre-service review is not required before a service is performed, selected services based on medical policy will be subject to review for medical necessity. If the service is determined not to be medically appropriate, the claim will deny as a non-covered or not a medically appropriate service and the participant will be responsible for the costs. **Impact:** 100% of applicable participants. If the participant does not agree with the post-service review decision, a written appeal may be submitted within 365 days of receipt of the

	decision. **Administrative Requirements:** As the incumbent carrier, this program is currently in place and will continue as currently administered.
Discharge Planning/Transition Care program	**Brief Description:** The Transitions Program proactively engages participants (telephonically and/or onsite in the facility) for all Lines Of Business while inpatient and provides them with comprehensive coordination of care services (discharge planning) to successfully and appropriately transition from the inpatient setting to home. The Transitions Unit also conducts calls after discharge and provides participants with the level of support, tools and appropriate resources needed to prevent unnecessary readmissions. Participants needing Short Term Case Management services will be managed by the Transition's Unit staff for up to 6 weeks post facility discharge as appropriate. Those participants requiring services beyond 6 weeks will be referred to a Complex Case Management Care Program upon facility discharge. **Impact:** 100% of applicable participants. Reduce unnecessary admissions; evaluate for medication reconciliation. Population: Impacts participant with inpatient admission; focus is on participants with Acute Readmission, LOS>10 days, High Risk inpatient participants based on predictive modeling. **Administrative Requirements:** As the incumbent carrier, this program is currently in place and will continue as currently administered.

Care Consultant Team	**Brief Description:** Clinicians are dedicated to meeting the participant's evolving needs and demands through provision of personalized health information, health care cost and quality transparency, easily accessible and understandable information and assistance with finding community resources. The Care Consultant Team process focuses on helping the participant navigate through the complex health care system. **Impact:** 100% of applicable participants. Population that access Care Consultant Team line for questions; request for information. Includes triage to refer participants to programs, benefit education to empower participants, link participants to community resources. **Administrative Requirements:** As the incumbent carrier, this program is currently in place and will continue as currently administered.
High Risk Maternity Program	**Brief Description:** This program is based on early identification, assessment and intervention of expectant mothers at-risk for a complicated pregnancy. Participants are identified during the first trimester. Case Managers provide access to information, education and services to improve clinical outcomes of the mother and improve the likelihood of delivering a healthy, full-term infant. There is collaboration among the Healthy Additions Program, Clinical Care teams and Medical Directors to promote positive outcomes for our expectant mothers. Proactive discharge planning and coordination of care needs post delivery are provided up to three months (as appropriate) in an effort to prevent readmissions. **Impact:** 100% of applicable participants. Population is female participants with high risk pregnancy. Includes participant education to facilitate healthy birth; remind participants of risk factors. **Administrative Requirements:** As the incumbent carrier, this program is currently in place and will continue as currently administered.

Neonatal Intensive Care Program (NICU)	**Brief Description:** The NICU Program provides mothers and/or legal guardians the necessary supportive outreach and access to information, education and services to influence the health of the infant and improve clinical outcomes. Components of the program include proactive identification, outreach and assessment of infants experiencing an admission to an acute NICU level to facilitate proactive discharge planning and comprehensive coordination of care services so transition to the next level and home is safe, appropriate and seamless. There is collaboration between Clinical Care, Clinical Review, Medical Directors and Pharmacy teams to ensure timely and appropriate information. Ongoing reassessment of problems, goals and interventions provide guidance and focus throughout participant engagement. Postpartum assessments include education and newborn specific reminders. **Impact:** 100% of applicable participants. Infants with complicated birth requiring NICU services. Includes coordination of complex services to facilitate discharge home. **Administrative Requirements:** As the incumbent carrier, this program is currently in place and will continue as currently administered.
Pediatric Program	**Brief Description:** This program is available to participants under age 19 with serious or complex health care problems or specific rare or core chronic condition diagnoses. Outreach from Case Managers provides information, education and access to services to address the specific care needs of the participant. Case Managers facilitate access to resources; optimize available health plan benefits; assist participants in gaining optimum health and ensure participants are in the appropriate cost effective setting to improve functional capability. **Impact:** 100% of applicable participants. Participant education on preventive services, facilitate access to care. Focus on population under age 19. **Administrative Requirements:** As the incumbent carrier, this program is currently in place and will continue as currently administered.

Complex Case Management	**Brief Description:** Case Managers within this program address participants with complex health needs or catastrophic events. They facilitate access to resources to improve functional capability; regain optimum health; maximize benefits and improve health outcomes. **Impact:** 100% of applicable participants. Participants 19 yrs and over that have health care needs not included in the specific condition programs. Includes participant education, coordination of care facilitates access to health care services and/or community resources. **Administrative Requirements:** As the incumbent carrier, this program is currently in place and will continue as currently administered.
PATCH-Physician Assessment, Treatment and Consultations at Home Services	**Brief Description:** The overarching principle of the PATCH approach is to provide a physician who can stand in for the participant's own treating physicians while the participant is temporarily or permanently unable to access such care. The physicians who are contracted, collaborate with the primary care physicians and case managers to provide comprehensive care in the home setting for high-risk participants who would not otherwise have access to such care. **Impact:** 100% of applicable participants. Participants unable to access office based physician services due to homebound status. Provides Readmission prevention. **Administrative Requirements:** Terms of participant contract apply for specialist service.

Oncology Support Program	**Brief Description:** Oncology Case Managers assist participants that have been diagnosed with cancer regardless of the type of cancer or proposed treatment plan (chemotherapy/radiation or palliative care). The Oncology Case Managers offer support for participants in making decisions about their illness and care; educate them about the disease; assist with symptom management; provide psychosocial and pharmacy support and facilitate care. Through an integrated approach, the Oncology Case Manager engages the participant, primary care physician, treating physician and palliative care resources as appropriate to impact care planning and decision-making. **Impact:** 100% of applicable participants. Participant education, coordination of care, facilitate access to health care services and/or community resources. **Administrative Requirements:** As the incumbent carrier, this program is currently in place and will continue as currently administered.
Hope Blue Palliative Care Program	**Brief Description:** Hope Blue is a voluntary palliative care program that connects participants suffering with the symptoms of a serious illness to physicians and nurse practitioners. Participants receive personalized treatment plans that provide symptom relief and enable an improved quality of life. Unlike hospice, the Hope Blue Palliative Care Program allows for a curative approach to care and treatment and is provided in the home, hospital, skilled nursing facility, assisted living facility or clinic. **Impact:** 100% of applicable participants. BCBSF participants with serious illnesses who are in need of specialized medical care called palliative care which focuses on providing relief from the symptoms, pain and distress of serious illness, whatever the diagnosis. Participants of any age with serious or multiple illnesses at any stage may be appropriate to be provided palliative care together with curative treatment. **Administrative Requirements:** For physician or ARNP visits, contracted under the palliative care provider contract (Hope Blue), home visit rates are higher.

Comfort Blue Hospice Program	**Brief Description:** Comfort Blue is provided for participants receiving hospice services. Hospice nurses educate participants about pain and symptom management. The Hospice nurse collaborate with physicians, local hospices, participants and family to understand and accept participant's goals and wishes and ensure care is provided in the appropriate setting. **Impact:** 100% of applicable participants. Focus on End of Life; participant education and coordination of care. **Administrative Requirements:** As the incumbent carrier, this program is currently in place and will continue as currently administered.
Chronic Condition Support Program	**Brief Description:** BCBSF provides an integrated Chronic Condition Support Program to participants by an NCQA Accredited vendor, Health Dialog. Through its Condition Support Program, Health Dialog provides services including education and support for participants with conditions including heart failure, diabetes, coronary heart disease, asthma, chronic obstructive pulmonary disease and other chronic conditions and comorbidities. Health Dialog provides decision support related to preference-sensitive medical decisions such as the treatment of back pain, breast cancer and prostate cancer. They provide symptom support related to common everyday problems such as fever, pain, injury, and infection. The Health Dialog team also provides healthy lifestyle support related to prevention and wellness such as screening tests, physical activity, and smoking cessation. Health Coaches provided by Health Dialog are specially trained healthcare professionals including, but not limited to nurses, dietitians, respiratory therapists and pharmacists. **Impact:** 100% of applicable participants. Health Dialog does targeted outreach to the top 10% of high risk chronic participants. **Administrative Requirements:** As the incumbent carrier, this program is currently in place and will continue as currently administered.

24/7 Nurse Line	**Brief Description:** Health Coaches are provided through Health Dialog and are available for calls 24 hours a day, 7 days a week. **Impact:** 100% of applicable participants. All participants may utilize the 24/7 nurseline. **Administrative Requirements:** As the incumbent carrier, this program is currently in place and will continue as currently administered.
Integrated Behavioral Health	**Brief Description:** New Directions Behavioral Health manages all Behavioral Health Services for BCBSF, which includes the Network, Utilization Management and Intensive Case Management. New Directions interfaces with BCBSF Case Managers. Providers and participants can access New Directions 24/7. **Impact:** 100% of applicable participants. All participants have 24/7/365 telephone access to licensed behavioral health clinicians to help them in urgent and emergent situations, and to connect with needed care and maintain safety. **Administrative Requirements:** As the incumbent carrier, this program is currently in place and will continue as currently administered.
Rare Condition Program	**Brief Description:** Program for participants requiring assistance with "complex care coordination and symptom management education." The focus is for the participants experiencing significant unmanaged disease symptoms. **Impact:** 100% of applicable participants. Low volume, high cost participants with one of the rare conditions; participant education and coordination of care. **Administrative Requirements:** As the incumbent carrier, this program is currently in place and will continue as currently administered

Transplant Case Management	**Brief Description:** Guide participants through the transplant process; provide assistance with access and prior approval; provide education and support during all stages of transplant and support continues for as long as assistance is needed after transplant. **Impact:** 100% of applicable participants. Focus on participants with pre and post transplant needs. **Administrative Requirements:** As the incumbent carrier, this program is currently in place and will continue as currently administered.